Shropshire Council

Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 14 March 2018

**Committee:**
**Joint Health Overview and Scrutiny Committee**

**Date:** **Thursday, 22 March 2018**
**Time:** **2.00 pm**
**Venue:** **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

**Members of Joint Health Overview and Scrutiny Committee**

**Shropshire**
Cllr Karen Calder (Co-Chair)
Madge Shineton
KiddCllr Madge Shineton
David Beechey (Co-optee)
Ian Hulme (Co-optee)
Mandy Thorn (Co-optee)

**Telford and Wrekin**
Cllr Andy Burford (Co-Chair)
Cllr Stephen Burrell
Cllr Hilda Rhodes
Carolyn Henniker (Co-optee)
Hilary Knight (Co-optee)
Dag Saunders (Co-optee)

Your Officers are:

**Amanda Holyoak** Scrutiny Committee Officer
Shropshire Council
01743 252718 amanda.holyoak@shropshire.gov.uk

**Jessica Tangye** Senior Democratic and Scrutiny Services Officer
Telford and Wrekin Council
01952 382061 jessica.tangye@telford.gov.uk

# AGENDA

**1 Apologies for Absence**

**2 Disclosable Pecuniary Interests**

Members are reminded that they must not participate in the discussion or voting on any matters in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

**3 Minutes**

To note that the minutes of the meeting held on 3 March 2018 will be presented to the next meeting of the Committee.

**4 Shropshire, Telford and Wrekin Midwife Led Unit Service Review** (Pages 1 - 78)

To receive and consider information on the Shropshire and Telford and Wrekin Midwife Led Unit Service Review, and particularly

The Current Position
Impact Assessment
Proposed Service Model
Consultation document and Consultation Plan

The following will be present at the meeting:

Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin Local Maternity System
Adam Gornall, Clinical Director – Women & Children, Shrewsbury & Telford NHS Hospital Trust (SaTH)
Dr Jessika Sokolov – Clinical Lead, Shropshire Clinical Commissioning Group
Sarah Jamieson – Head of Midwifery – SaTH

**5 Co-Chair's Update**

Public Document Pack

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**5 Co-Chair's Update**

# Shropshire , Telford and Wrekin Midwife Led Unit (MLU) Review : Proposed Service model

Dr Jessica Sokolov: Clinical Director Women and Children Services and Deputy Chair Shropshire CCG

Joint HOSC
March 22 2018

# Update: why was the review necessary?

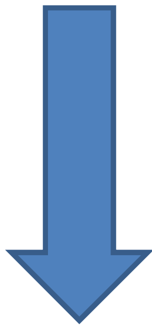
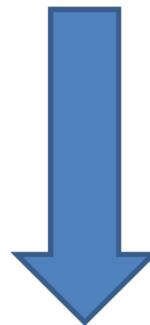
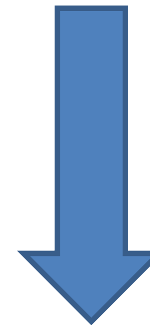
- Public concerns at SCCG board end of 2016
- SaTH concerns re : staffing model and funding model
- Reminder of current provision

# Designing the service: The process

**Phase 1**
Analysing existing information

**Phase 2**
Gathering new information

**Phase 3**
Co-design workshops

**Proposed Service Model**

# Proposed service model: Pre-pregnancy

Outside the direct scope of the review, but included for completeness and will be passed on to the Local Maternity System for action:

- Improved information about the importance of good health during pregnancy
- Improved information sharing between professionals
- Services to improve the health of women (mental and physical) before pregnancy

# Proposed service model: Pregnancy

- At least 5 maternity hubs across the county which will be available for at least 12 hours a day for planned midwifery led care.

- It is proposed that there will be at least one maternity hub in at least each of the following areas: Telford, Shrewsbury, Bridgnorth, Ludlow, Oswestry.

- Access to advice and support from a midwife 24/7. This will include an excellent triage service available 24/7 for women to ring when they think they're in labour to help to ensure that they get to their chosen place of birth on time.

# Proposed service model: Pregnancy

It is proposed that the same types of service are available at each maternity hub, including:

- Antenatal care from a midwife and support from women's services assistants
- Planned antenatal appointments with an obstetrician
- Scanning and fetal monitoring
- Antenatal day assessment, including CTG (where baby's heart rate and movements are monitored)
- Support with emotional wellbeing and mental health
- Support with long term conditions during pregnancy
- Healthy lifestyle services including smoking cessation and weight management services
- Information and advice about pregnancy and parenthood
- Information and advice about birth options
- Peer support

# Proposed service model: Pregnancy

Other features of this part of the model include:

- The development of a 'becoming a family' plan
- Receive care that plans for women to give birth in a midwife led setting
- Women get to know the place where they plan to give birth and meet the midwives who are likely to deliver their baby
- Staff work within a team with a mix of skills
- Women will not need to make a decision about where they plan to give birth until later on in pregnancy
- Women have a say and feel fully involved in making decisions about their care, including when unexpected things happen
- Women and staff have up to date information electronically
- Women and staff have a say in decisions about the service, including service improvements.

# Proposed service model: Birth

- Full range of birth settings to choose from (Consultant led unit, Alongside Midwife Led Unit, Freestanding Midwife Led Unit and Home Birth).

- Births within Shropshire to be available at:
    - Consultant led Unit at Princess Royal Hospital
    - Alongside midwife led unit at Princess Royal Hospital
    - Freestanding midwife led unit at Royal Shrewsbury Hospital
    - Home Birth

- The choice of birth settings will include places over the Shropshire border, which may be more convenient for those living on the edges of the county.

# Proposed service model: Birth

Other features of this part of the model include:

- The MLUs in Telford and Shrewsbury may also act as the maternity hubs for antenatal and postnatal care.

- Women have a say and feel fully involved in making decisions about their care, including when unexpected things happen.

- Women and staff have up to date information electronically.

- Women and staff have a say in decisions about the service, including service improvements.

# Proposed service model: Birth

This proposed model is designed to increase the number of midwife-led births by:

- Over time, improving the health of women during pregnancy.
- Changing pathways in antenatal care so that all women receive care that plans for a midwife led birth, unless this won't be safe for the woman or her baby, or she chooses consultant led care for another reason.
- Enabling women during pregnancy to get familiar with the midwife led units and the staff who work there.
- Enabling women to make a decision about their preferred place of birth later in pregnancy.
- Moving the alongside midwifery led unit closer to the consultant led unit in order for a different level of risk to be safely managed.

# Proposed service model: Postnatal

- Community midwives and women's support assistants available 24/7.

- At least 5 maternity hubs across the county which will be available for at least 12 hours a day for planned midwifery led care.

- It is proposed that there will be at least one maternity hub in at least each of the following areas: Telford, Shrewsbury, Bridgnorth, Ludlow, Oswestry.

- Inpatient postnatal stay available on Princess Royal Hospital postnatal ward for women who need it.

# Proposed service model: Postnatal

It is proposed that the same types of service are available at each maternity hub, including:

- Postnatal care from a midwife
- Support and advice from women's services assistants with regards to baby care
- Newborn checks and screening
- Drop-in service or planned access during a 12 hour period
- A space for women and their families to reflect on the birth experience
- Support with emotional wellbeing and mental health
- Support with confidence building and bonding
- Support with feeding
- Support with long term conditions postnatally
- Healthy lifestyle services
- Information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking
- Peer support

# Proposed service model: Postnatal

Other features of this part of the model include:

- Staff work within a team with a mix of skills.
- Women have a say and feel fully involved in making decisions about their care, including when unexpected things happen.
- Women and staff have up to date information electronically.
- Women and staff have a say in decisions about the service, including service improvements.

# Next steps for the review

Proposed model approved to progress to consultation by Shropshire CCG and Telford and Wrekin CCG following completion of the NHSE Assurance process.

HOSC will receive results of consultation.

**Dr Jessica Sokolov**
Clinical Director Women and Children Services and Deputy Chair Shropshire CCG

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|---|---|
| Meeting | Shropshire, Telford and Wrekin Joint Health Overview Scrutiny Committee<br>Thursday 22nd March 2018 |
| Title of the report: | Shropshire, Telford and Wrekin Midwife Led Unit Review |
| Author of the report: | Fiona Ellis – Programme Manager; Shropshire, Telford and Wrekin Local Maternity System |
| Presenter: | Dr Jessica Sokolov – Deputy Clinical Chair, Shropshire CCG |

**Purpose of the report:**

To inform Joint HOSC of the findings of the Shropshire, Telford and Wrekin Midwife Led Unit Review and to present the proposed model for approval.

**Key issues or points to note:**

The review findings suggest that:

- The current model is not clinically sustainable and that the current staffing levels and skill mix are not appropriate for the demand. Improvements to staffing levels and skill mix need to be made as well as addressing issues around staff wellbeing.
- The current model is safe, but currently inequitable. Further consideration needs to be given to how the performance and quality of midwifery led care can be further improved to achieve better outcomes for women and their families. Once published, the findings of the wider reviews currently taking place will also need to be taken account of (i.e. the Secretary of State Review, and Royal College Obstetricians and Gynaecologists Review).
- Improvements to rural access could be made with regards to ensuring consistency in community provision across the county. Consideration also needs to be given with regards to whether the long journey times can be improved for the women needing to access consultant led care, but live a distance from Princess Royal Hospital.
- The driver for this review should be how to get services working as efficiently as possible, to get the best use of funds, staff and assets with the principle objectives being clinical sustainability, equity of access and improved outcomes.

A new service model is proposed that seeks to improve clinical and financial sustainability of midwifery led care as well as improving access to services and outcomes for women and their families.

**Actions required by HOSC:**

It is recommended that HOSC:

- Note the review findings and proposed service model.

**Shropshire, Telford and Wrekin Midwife Led Unit Review**

## 1. Executive Summary and Actions Required

The review findings are that:

(i) The current model is not clinically sustainable. The current staffing levels and skill mix are not appropriate for the demand. Improvements to staffing levels and skill mix need to be made as well as addressing issues around staff wellbeing.

(ii) The current model is safe, but further consideration needs to be given to how the performance and quality of midwifery led care can be further improved to achieve better outcomes for women and their families. Once published, the findings of the wider reviews (i.e. the Secretary of State Review, and Royal College Obstetricians and Gynaecologists Review) currently taking place will also need to be taken account of.

(iii) Improvements to rural access can be achieved by ensuring consistency in community provision across the county. Consideration also needs to be given with regards to whether the long journey times can be improved for the women needing to access consultant led care, who have significant travel times to Princess Royal Hospital.

(iv) The driver for this review has been how to get the services working as efficiently as possible, to get best use of funds, staff and assets with the principle objectives being clinical sustainability, right care, and best value. The CCG will not pay above tariff for maternity services and therefore should support efforts to remodel services that will drive cost out for SATH whilst improving clinical sustainability, equity of access, and improved outcomes.

1.1. A new service model is proposed that seeks to improve clinical and financial sustainability of midwifery led care as well as improving access to services and outcomes for women and their families.

1.2. Shropshire, Telford and Wrekin Joint Health Overview Scrutiny Committee are asked to note the findings of the midwife led unit service review.

## 2. Introduction

2.1. Shropshire, Telford and Wrekin maternity services are provided by Shrewsbury and Telford Hospitals NHS Trust (SaTH). There are five Midwife Led Units (MLUs) that provide antenatal, birth and postnatal care in Shrewsbury, Ludlow, Oswestry, Bridgnorth and Wrekin. Wrekin is on the same site as the Consultant Led Unit at Princess Royal Hospital in Telford. In addition there are two Community Hubs at Market Drayton and Whitchurch where antenatal, home birth and postnatal care is provided.

2.2. The MLU operating model has remained consistent over the past thirty years undertaking all antenatal bookings and both high and low risk antenatal care for the Consultant Unit. The MLUs also deliver antenatal and postnatal community care, postnatal inpatient care as well as low risk births.

2.3. Shrewsbury and Telford Hospital NHS Trust have raised concerns regarding the sustainability of the current MLU model and in response, Shropshire Clinical Commissioning Group (CCG) has led a comprehensive service review on behalf of both Shropshire CCG and Telford and Wrekin CCG.

2.4. The purpose of Shropshire, Telford and Wrekin midwife-led unit service review is to review:

- whether or not the clinical model of delivery currently in place in Shropshire, Telford and Wrekin is clinically sustainable
- the safety of, and the clinical outcomes from, the current model and to establish whether or not these are acceptable for Shropshire, Telford and Wrekin patients
- any quality concerns relating to the service and make recommendations to address these
- staffing of the units to ensure this is appropriate for the requirements of the units and that there is a clear workforce plan to support service delivery
- any concerns relating to rural access to the services and make recommendations to address these
- the financial sustainability of the five MLUs. This can only be done within a financial review of the whole of the SATH Maternity service and tariff income
- whether the current model provides value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability and make recommendations to address this where this is not the case

2.5. The terms of reference for the review state that where the review identifies issues in relation to value for money, access, safety, quality, clinical outcomes, clinical sustainability or financial sustainability, alternative models of service provision will be developed in partnership with stakeholders.

2.6. In addition to addressing the particular considerations for this review, the work also took account of the national direction for maternity services as set out in the 2016 Maternity Review Report. *Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)*[1].

2.7. The midwife led unit review was undertaken in three phases:

- Phase 1 (Analysis of existing information) considered a range of existing information from a number of different organisations.[2]
- Phase 2 (Gathering new information) included gathering detailed information from women and their families as well as professionals working in or with maternity services through a series of in-depth interviews.
- Phase 3 (Co-design workshops) involved commissioners, women and their families, staff and community members with an interest in midwifery led care discussing together what a new model of care may need to include.

2.8. The information gathered during Phase 1 and Phase 2 was used to inform discussion in the co-design workshops in Phase 3.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[2] Different organisations use a variety of data definitions and collection methods. As several data sources were used to inform this report, there is slight variability in some of the figures reported.

## 3. Summary Findings

3.1. The findings described below relate to midwife led services. However, it should be noted that these services do not operate in isolation and are delivered within the context of maternity services as a whole. Therefore, where relevant reference is made to how other elements of maternity provision may affect/be affected by changes in midwifery led care.

3.2. *Is the clinical model of delivery currently in place in Shropshire, Telford and Wrekin clinically sustainable? Is the staffing of the units appropriate for the requirements and is there a clear workforce plan to support service delivery?*

3.3. The findings of Birthrate Plus[3] (BR+) in April 2017 suggest that an increase in staffing is required in order for the current service model to be sustainable. The BR+ report produced for SaTH maternity services suggests that an overall increase in staffing is required, but that the smaller MLUs are over-staffed for the level of activity.

3.4. BR+ states that for the MLUs and community bases, the shortfall of 13.06wte are not just midwives and a significant number can be appropriately qualified maternity support workers (MSW) assisting with postnatal care in the MLUs and community. An estimated 10.66wte could be MSWs across the total community, reducing the midwifery shortfall to 2.40wte. For the consultant-led unit a shortfall of 15.56wte was identified, of which an estimated 6.0wte could be appropriately qualified maternity support workers, reducing the midwifery shortfall in the consultant led unit to 9.56wte.

3.5. Recent increases in staff absences have increased the fragility of the service. The findings of the review suggest that the skills of existing staff aren't being utilised in the most efficient way. Women giving birth in consultant led units don't always get 1:1 care in labour, whereas women giving birth in midwife led units or at home have at least 1:1 care in labour. There are other models of care which may offer greater sustainability and need to be considered.

3.6. Staff morale is low. Whilst in general relationships within teams are good, relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported by management. Women's support assistants and midwives report that recent changes are compromising the care they are able to offer as there is not enough time during appointments and home visits. Staff are worried that 'something will be missed' as they don't have enough time with women.

3.7. Increasingly, midwives do not feel in control of their working lives. They feel frustrated and angry. Staff feel disengaged from and let down by senior managers. Midwives report that not feeling in control is impacting on their work and home lives and on their emotional wellbeing, health and happiness. Staff feel they are letting their ladies down – especially in areas where there have been MLU closures.

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[3] Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making. The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus

3.8. **The findings suggest that the current model is not clinically sustainable and that the current staffing levels and skill mix are not appropriate for the demand. Improvements to staffing levels and skill mix need to be made as well as addressing issues around staff wellbeing.**

3.9. *Is the safety of, and are the clinical outcomes from, the current model acceptable for Shropshire, Telford and Wrekin patients? Are there any quality concerns relating to the service?*

3.10. The CCG Clinical Quality and Review processes consider the safety and clinical outcomes from the current model to be acceptable. However, the outcomes and recommendations from wider reviews will need to be considered, once published. In addition, consideration needs to be given to how the current performance around safety and clinical outcomes can be further improved, as well as how midwifery services can work with other wider services, such as those commissioned by the Local Authority to further improve longer term outcomes for women and their families.

3.11. Whilst women did not report any issues relating to quality and safety, some concerns were raised by midwives.[4] Midwives reported that changes in working practices were compromising continuity and their close relationships with women. Midwives perceive that it is becoming more difficult to support women well during the antenatal period due to changes in the way care is being provided. Midwives reported that as a result of interim changes in the care model being implemented, their experience of being able to identify when a woman is struggling was changing. Some said they now had less time and a short visit was not enough to spot that women were struggling. They were concerned that problems would be missed.

3.12. Midwives also say the way call outs and on call arrangements are managed is getting in the way of great - and even safe - maternity care. Staff talk about "being pulled out" of their day job to work in the consultant led unit, and how disruptive that is. Working in different and unfamiliar environments is difficult and some staff feel it is risky.

3.13. **The findings suggest that whilst the current model is safe, further consideration needs to be given to how the performance and quality of midwifery led care can be further improved to achieve better outcomes for women and their families. Once published, the findings of the wider reviews currently taking place will also need to be taken account of.**

3.14. *Are there any concerns relating to rural access to the services?*

3.15. Antenatal and either community or inpatient post-natal care is delivered within women's communities, but there is some geographical variability with regards to the local offer, and this is something that might be improved by consideration of alternative models of care. Any new model would need to reflect the need for all service users in Shropshire, Telford and

[4] The CCGs subsequently took action to look further into the concerns raised and take any action as required to ensure that services are safe and any issues regarding relationships between management and frontline staff are addressed.

Wrekin to have a consistent, accessible service, recognising the long travel times some rural populations face if they need to travel for Consultant –led care under the current system.

3.16. Families and staff told us that in Shropshire, Telford and Wrekin transport is a really important factor in their decisions and choices around birth and maternity care. People worried most about travelling to their place of birth when they were in labour and about birth before arrival. Because those who had to travel to the consultant led unit were usually also the ladies at highest risk, both staff and families worried that if more people were travelling and there was no or limited access to midwife services locally in case of emergencies, birth outcomes would get worse.

3.17. **The findings suggest that improvements to rural access could be made with regards to ensuring consistency in community provision across the county. Consideration also needs to be given with regards to whether the long journey times can be improved for the women needing to access consultant led care, but live a distance from Princess Royal Hospital.**

3.18. *Are the MLUs financially sustainable?*

3.19. SaTH have informed commissioners that MLUs cost £1million more to run than the income they receive from the maternity tariff for the midwife led units. Whilst the two larger MLUs operate below tariff, the three smaller MLUs in Bridgnorth, Ludlow and Oswestry operate at a loss (£355k, £666k, £699k respectively). However, the Midwife Led Units do not operate in isolation and activity and costs in other areas of the service/provider function impact upon the current financial position of the Midwife Led Units[5].

3.20. The biggest cost for MLUs is staffing. Therefore, it is important that this review considers how to ensure the staffing element is as efficient and effective as possible in order to get best value. It will be important to consider what skills are likely to be required during the day/night and in what volume. The current service configuration doesn't best meet demand. For example, at night each of the smaller MLUs has a midwife on site at the unit. This is the case whether there are women birthing/having a postnatal stay in the unit or not. However, at night the highest demand for midwives is in the consultant led unit, where currently they often have a shortage of midwives overnight.

3.21. A significant cost pressure relating to maternity services, including MLUs is in relation to the Clinical Negligence Scheme for Trusts (CNST). This is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme. For SaTH maternity services as a whole, the cost of this is nearly £5.8million per year, with a proportion of this apportioned to MLUs.

3.22. Bridgnorth, Ludlow and Oswestry MLUs are sited in buildings not owned by SaTH. Therefore, there are additional costs associated with rent for these units.

[5] SaTH report losses of £7.263M against maternity services as a whole.

3.23. **The findings suggest that the driver for this review should be how to get services working as efficiently as possible, to get the best use of funds, staff and assets with the principle objectives being clinical sustainability, equity of access and improved outcomes.**

3.24. *Does the current model provide value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability?*

3.25. **Information gathered to date demonstrates the need to explore different service configurations that offer appropriate rural access, improved clinical outcomes, safety, and clinical sustainability alongside better value for money. Any new service configuration will need to ensure that systems are as efficient as possible and that staff expertise is utilised in the most effective way. In addition, better integration with other services would help to deliver an improvement in outcomes for women and their families.**

## 4. Proposed Changes

4.1. Not all of the proposed changes below relate directly to the midwife led care that SaTH provide. However, the wider changes for action by the Local Maternity System[6] have also been included here for completeness.

[6] The national review of maternity services 'Better Births' required each area in England to bring providers and commissioners together to operate as local maternity systems (LMS), to lead the transformation required in maternity services. Our local LMS is the Shropshire, Telford and Wrekin LMS. The MLU review is part of the transformation that will be delivered by the Shropshire, Telford and Wrekin LMS.

| MLU Review Proposed Changes Summary Table | | |
|---|---|---|
| **Current Provision** | **Proposed Provision** | **Rationale** |
| **Pre-Pregnancy** | | |
| All women have access to universal public health services relating to healthy lifestyles. Women with a specialist need have access to mental health services provided by South Staffordshire and Shropshire NHS Foundation Trust (SSSFT). | It is proposed that, through the Local Maternity System, Public Health and Mental Health services are enhanced in order to provide multi-disciplinary information and support with regards to getting pregnant and being healthy during pregnancy. This should include information, advice and support from professionals in relation to:<br><br>- Contraception and Sexual Health<br>- Conception<br>- Mental Health<br>- Healthy Lifestyles<br>- Long Term Conditions<br><br>In addition, it is proposed that the services pre-pregnancy also offer comprehensive information on-line as well as facilitating peer support networks. New pathways, joint training and information sharing to enable professionals in different services to work well together, including improved information sharing, rotation of training across professionals and multi-agency information available on-line for professionals.<br><br>Note : These services sit outside of the scope of the MLU review, but are included here for completeness. This proposal will be put forward to the LMS for action. | Health of women in pregnancy will be improved. This will facilitate a greater number of low risk, midwife led births as well as improving longer term health outcomes for women and their families. |

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| **Pregnancy** | | |
|---|---|---|
| Access to services is unclear and disjointed, with some women accessing services via their GP and some contacting maternity services directly.<br><br>Women receive antenatal care from community midwives, who operate from 5 MLUs (1 x Alongside (AMU), 4 x Freestanding (FMU)) and 2 community bases.<br><br>Ultrasound scanning is available in MLUs in most parts of the county.<br><br>Day Assessment is available in MLUs in some parts of the county.<br><br>Obstetric clinics are available in MLUs in some parts of the county.<br><br>Women with an identified mental health need receive support through a specialist service provided by SSSFT. | It is proposed that access to maternity care is improved through self-referral via a single phone number to register directly with maternity services. In addition, improved electronic and online information should be developed, which includes a broad range of local information and advice for pregnant women and their families.<br><br>Maternity Hubs across the county should be developed that are available for at least 12 hours a day for midwifery led care. A range of different services should also be available at the hubs. It is proposed that these maternity hubs replace the current model of MLUs for midwifery led care (note in the Birth section that it is proposed that 1 x AMU and minimum 1 X FMU are retained – these may also act as maternity hubs for those areas).<br><br>The same services should be available in each of the maternity hubs at times which suit women accessing the services. The location of the hubs will be defined by likely population demand and will be easily accessible by car and public transport. Services available will include;<br><br>- Antenatal care from a midwife<br>- Support from Women's services assistants<br>- Planned antenatal appointments with an obstetrician | The maternity hubs will ensure that women have equal access to services across the county. Women will have improved access to a range of services related to pregnancy – they can access them from the same place and can build relationships with peers accessing the services in order to support each other.<br><br>The sustainability of the service will be improved through more integrated working and improved skill mix within the midwifery led care service. In addition, service availability will be shaped around local demand and activity. The staffing model will require fewer midwives to 'staff' bases, enabling more midwives to be able to flexibly respond to demand.<br><br>Services will be close to home for women and more joined up. Local services will be available at times that suit the women who use them. |

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|  |  |  |
|---|---|---|
|  | - Scanning and fetal monitoring for all trimesters (not including labour)<br><br>- Antenatal day assessment, including CTG monitoring<br>- Support with emotional wellbeing and mental health (action for LMS)<br>- Support with long term conditions during pregnancy<br>- Healthy lifestyle services, including smoking cessation and weight management services (action for LMS)<br>- Information and advice about pregnancy and parenthood including antenatal classes/groups, breastfeeding, baby care and life skills such as budgeting and cooking (some provided by SaTH, some for action by LMS)<br>- Information and advice about birth options<br>- Peer Support (action for LMS)<br><br>A team of community midwives who have a caseload that is in line with national guidance will support women with planned antenatal care. They will have strong links with local GPs and will be supported by maternity support workers who are able to assist with tasks such as routine phlebotomy, urine testing and weight measurements.<br>Women will have access to midwife advice and support 24/7. This will include advice |  |

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|---|---|---|
| | and support in person, through video call or over the phone.<br><br>Women and the professionals working with them will have access to up to date information electronically (action for LMS).<br>Peer support networks are in place, where women and their partners are able to link in with others if they want to, to share experiences through initiatives such as drop in 'cafes' and online networks (action for LMS). | |
| **Birth** | | |
| Women have a full choice of birth options, delivered through:<br>1 x consultant led unit<br>1 x AMU<br>4 x FMU<br>Home Birth | Women have a full choice of birth options and will be able to give birth at the consultant led unit at Princess Royal Hospital (PRH), at the Alongside MLU at PRH, a Freestanding MLU in Shrewsbury and at home.<br><br>A community team will be available 24/7 for midwife led births in the midwife led units and at home.<br><br>There will be improved pathways with maternity services over the border (particularly Wrexham, Hereford and Worcester) to facilitate easier access to services in those areas for women choosing to do so. | Clinical and Financial sustainability will be improved through more effective use of skill mix within teams. Whilst maintaining a full choice of birth options within county, reducing the number of MLUs will enable staffing to be deployed more effectively in line with demand.<br><br>The current AMU, whilst technically an AMU as it is on the same site as the consultant unit, is not within close enough proximity to the consultant led unit for a greater level of risk to be safely managed in the AMU. Consideration needs to be given to re-locating the AMU closer to the consultant led unit in order to seek to facilitate an increase in midwife led births. SaTH are currently exploring this, as there are other services |

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| | | |
|---|---|---|
| | | currently within the women and children's centre at PRH which could potentially be moved to elsewhere in the hospital, enabling the AMU to be closer to the consultant unit.<br><br>The proposed model is designed to increase the number of midwife led births by: Over time, improving the health of women during pregnancy; Changing pathways in antenatal care so that all women receive care that plans for a midwife led birth, unless this won't be safe for the woman or her baby, or she chooses consultant led care for another reason; Enabling women to make a decision about their preferred place of birth later in pregnancy; moving the alongside midwifery led unit closer to the consultant led unit in order for a different level of risk to be safely managed. |
| **Postnatal** | | |
| Women have access to inpatient postnatal care in MLUs and as outpatients at home. | A team of community midwives and women's support assistants will be available 24/7 to offer advice and support after the woman has given birth (this will be available from as soon as the mother returns home, or as soon as the midwife who delivered the baby at home has left). This support and advice will be available either in person, through a video call, or over the phone.<br><br>Maternity Hubs across the county will be | Excellent postnatal care will be available consistently across the county. Clinical and Financial sustainability will be improved through more effective use of skill mix within teams and with staffing configuration better matching service demand. |

| | | |
|---|---|---|
| | available for at least 12 hours a day for planned midwifery led care. A range of other different services will also be available at the hubs. The same services will be available in each of the maternity hubs at times which suit women accessing the services. Services available will include;<br>- Postnatal care from a midwife<br>- Support from Women's services assistants<br>- Newborn checks and screening<br>- Drop-in service or planned access during a 12 hour period to enable support, for example with feeding, confidence building, baby care skills<br>- A space for women and their families to reflect on the birth experience<br>- Support with emotional wellbeing and mental health<br><br>- Support with confidence building and bonding<br>- Support with feeding<br>- Support with long term conditions postnatally<br>- Healthy lifestyle services<br>- Information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking<br>- Peer Support | |

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## 5. Options for service delivery

5.1. A number of options have been scoped out to evidence sustainability and cost effectiveness of the proposed service model. The options listed are not exhaustive. There are many other options available that would consider different skill mix, opening times etc. However, the following options provide a guide to potential staffing delivery models that demonstrate improved sustainability and efficiency.

5.2. The options below only include the staffing that will be required to staff the services which will have a particular building as a base. The proposed midwifery led care service model also includes 'community based' care, which will include unplanned antenatal and postnatal care delivered 24/7 at various locations in the community, including women's homes as well as some planned care delivered in the community. It also includes a 24/7 home birth provision. It is anticipated that the level of staffing associated with delivering this type of care may also see some efficiencies through increased skill-mix and better use of technology. However, this has not been explored in depth at this stage.

5.3. The attached options demonstrate that the proposed service model will be more sustainable than existing provision. In addition to improved use of technology, the improved sustainability will be achieved through:

- Reducing the number of sites requiring staffing 24/7
- Improving skill mix
- Releasing capacity to match demand

5.4. The attached options have been developed in line with guidance relating to caseload and midwife to birth ratios. All of the options include the retention of a full mix of birthing options through the provision of a consultant unit, an alongside MLU, a freestanding MLU and home birth provision all available 24/7 (unless stated otherwise). These will be supported by maternity 'hubs' across the county which will be open for 12 hours a day, offering antenatal and postnatal day care, maternal and neonatal assessment, ultrasound, and multi professional clinics and advice, volunteer and third sector support. These services will also be available at the alongside and freestanding MLU.

5.5. The options demonstrate that the proposed model could release up to 27 midwife shifts and 27 midwife support worker shifts per week, equating to over 17 WTE in total. The table below summarises each of the options (presented in more detail in Appendix 1) with additional commentary as to the suitability of each option.

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**Shropshire, Telford and Wrekin MLU Review : Options for delivery summary table**

| Option | Description | Efficiency | Viable? | Comments |
|---|---|---|---|---|
| Current Provision:<br>1 x Consultant Unit<br>1 x Alongside MLU<br>4 x Standalone MLU | | N/A | No | The service is currently not sustainable for the provider. The service configuration does not currently match demand and the availability of services is inconsistent across the county. |
| 1 | Change one rural MLU to a 12 hour Hub operating over either 5 or 7 days. | Will release:<br>5.76 WTE (5 days)<br>4.48 WTE (7 days) | No | Does not reflect the need for consistent services across the county. Does not reflect the need for staffing to be in line with demand. Does not release enough capacity to ensure sustainability. |
| 2 | Change two rural MLU to a 12 hour Hub operating over either 5 or 7 days. | Will release:<br>11.52 WTE (5 days)<br>8.96 WTE (7 days) | No | Does not reflect the need for consistent services across the county. Does not reflect the need for staffing to be in line with demand. |
| 3 | Change three rural MLU to a 12 hour Hub operating over either 5 or 7 days. | Will release:<br>17.28 WTE (5 days)<br>13.44 WTE (7 days) | Yes | Will enable consistent services across the county. Better matches staffing/services to demand. |
| 4 | Change three rural MLU to a 12 hour Hub operating over either 5 or 7 days and change the standalone MLU to operate for 12 hours a day over 7 days a week. | Will release:<br>21.76 WTE (5 days)<br>17.92 WTE (7 days) | No | Does not provide full choice of birth option 24/7. |
| 5 | Change three rural MLU to a 12 hour Hub and introduce an additional 12 hour Hub operating over either 5 or 7 days in the Market Drayton/Whitchurch area. | Will release:<br>14.08 WTE (5 days)<br>8.96 WTE (7 days) | Yes | Will enable consistent services across the county. Better matches staffing/services to demand. May not be as sustainable as Option 3. |

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5.6. Of the options explored, option 3 is felt to be the preferred model. Whilst Option 5 is optimal, it is not thought to be as sustainable as Option 3.

5.7. There are many variables possible within the options presented. The proposed service model is designed to be flexible, in order to adapt to changes in need and demand as required. In taking the recommendations of this review further, more detailed work will need to be undertaken with the service provider(s) to confirm the detail of the final model of delivery.

## 6. Summary and Conclusion

6.1. The service model proposed will improve clinical and financial sustainability and is in line with the requirements of Better Births. Access to care will be more consistent with a greater range of services available across the county. The service will aim to increase midwife led births through a number of initiatives, including moving the decision about preferred place of birth to later in pregnancy, linking in with public health schemes to improve the health of women in pregnancy and re-locating the alongside midwifery led unit closer to the consultant led unit.

6.2. The proposed model of midwifery led care is very different to the current service provision. Some elements of the proposed model may receive public challenge. However, the proposed new model will deliver an excellent, sustainable model of integrated care that is widely accessible across the county.

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**Appendix 1**

**MLU Review : Proposed Model Staffing Options**

**Current configuration:**

| | Shifts | Midwives per shift | Total midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant Unit | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Wrekin MLU | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Shrewsbury MLU | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry MLU | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Ludlow MLU | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Bridgnorth MLU | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| | **12** | **18** | **36** | **7** | **14** | **42** | **252** | **98** |

**Option 1a -** One hub with 12 hour opening 7 days per week, reducing midwife shifts by 7 and MSW shifts by 7:

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant Unit | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| | **11** | **18** | **35** | **7** | **13** | **42** | **245** | **91** |

**Option 1b -** One hub with 12 hour opening 5 days per week, reducing midwife shifts by 9 and MSW shifts by 9:

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant Unit | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| | **11** | **18** | **35** | **7** | **13** | **40** | **243** | **89** |

**Option 2a -** Two hubs with 12 hour opening 7 days per week, reducing midwife shifts by 14 and MSW shifts by 14 :

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| | **10** | **18** | **34** | **7** | **12** | **42** | **238** | **84** |

**Option 2b -** Two hubs with 12 hour opening 5 days per week, reducing midwife shifts by 18 and MSW shifts by 18 :

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| | **10** | **18** | **34** | **7** | **12** | **38** | **234** | **80** |

**Option 3a -** Three hubs with 12 hour opening 7 days per week, reducing midwife shifts by 21 and MSW shifts by 21:

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| | **9** | **18** | **33** | **7** | **11** | **42** | **231** | **77** |

**Option 3b -** Three hubs with 12 hour opening 5 days per week, reducing midwife shifts by 27 and MSW shifts by 27 :

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| | **9** | **18** | **33** | **7** | **11** | **36** | **225** | **71** |

**Option 4a -** Three hubs with 2 hour opening 7 days per week, and the standalone MLU moves to 12 hours 7 days per week, reducing midwife shifts by 28 and MSW shifts by 28:

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| | **8** | **18** | **32** | **7** | **10** | **42** | **224** | **70** |

**Option 4b -** Three hubs with 12 hour opening 5 days per week, and the standalone MLU moves to 12 hours 7 days per week, reducing middwife shifts by 34 and MSW shifts by 34:

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| | **8** | **18** | **32** | **7** | **10** | **36** | **218** | **64** |

**Option 5a -** Four hubs with 12 hour opening 7 days per week, reducing midwife shifts by 14 and MSW shifts by 14 :

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| Additional Hub (Whitchurch/Market Drayton area) | 1 | 1 | 1 | 1 | 1 | 7 | 7 | 7 |
| | **10** | **19** | **34** | **8** | **12** | **49** | **238** | **84** |

**Option 5b -** Four hubs with 12 hour opening 5 days per week, reducing midwife shifts by 22 and MSW shifts by 22:

| | Shifts | Midwives per shift | Total Midwives per day | MSW per shift | Total MSW per day | Days Open | Total Midwife Shifts | Total MSW Shifts |
|---|---|---|---|---|---|---|---|---|
| Consultant | 2 | 12 | 24 | 2 | 4 | 7 | 168 | 28 |
| Alongside (Wrekin MLU) | 2 | 2 | 4 | 1 | 2 | 7 | 28 | 14 |
| Stand alone (Shrewsbury MLU) | 2 | 1 | 2 | 1 | 2 | 7 | 14 | 14 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Oswestry/Ludlow/Bridgnorth Hub | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| Additional Hub (Whitchurch/Market Drayton area) | 1 | 1 | 1 | 1 | 1 | 5 | 5 | 5 |
| | **10** | **19** | **34** | **8** | **12** | **41** | **230** | **76** |

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Shropshire, Telford and Wrekin Midwife Led Unit Service Review
Draft Review Report
6 December 2017

## 1. Introduction

1.1. Shropshire, Telford and Wrekin maternity services are provided by Shrewsbury and Telford Hospitals NHS Trust (SaTH). There are five Midwife Led Units (MLUs) that provide antenatal, birth and postnatal care in Shrewsbury, Ludlow, Oswestry, Bridgnorth and Wrekin, one of which (Wrekin) is on the same site as the Consultant Led Unit at Princess Royal Hospital in Telford. These units are supported by two Community Hubs at Market Drayton and Whitchurch where antenatal, home birth and postnatal care is provided.

1.2. The MLU operating model has remained consistent over the past thirty years undertaking all antenatal bookings and both high and low risk antenatal care for the Consultant Unit. The MLUs also deliver antenatal and postnatal community care, postnatal inpatient care as well as low risk births.

1.3. Shrewsbury and Telford Hospital NHS Trust have raised concerns regarding the sustainability of the current MLU model and in response, Shropshire Clinical Commissioning Group (CCG) has led a comprehensive service review on behalf of both Shropshire CCG and Telford and Wrekin CCG.

1.4. The purpose of Shropshire, Telford and Wrekin midwife-led unit service review is to review:

- whether or not the clinical model of delivery currently in place in Shropshire, Telford and Wrekin is clinically sustainable
- the safety of, and the clinical outcomes from, the current model and to establish whether or not these are acceptable for Shropshire, Telford and Wrekin patients
- any quality concerns relating to the service and make recommendations to address these
- staffing of the units to ensure this is appropriate for the requirements of the units and that there is a clear workforce plan to support service delivery
- any concerns relating to rural access to the services and make recommendations to address these
- the financial sustainability of the five MLUs. This can only be done within a financial review of the whole of the SATH Maternity service and tariff income
- whether the current model provides value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability and make recommendations to address this where this is not the case

1.5. Where the review identifies issues in relation to value for money, access, safety, quality, clinical outcomes, clinical sustainability or financial sustainability, alternative models of service provision will be developed in partnership with stakeholders.

1.6. This document reports on the findings of:

- Phase 1 (Analysis of existing information) of the Shropshire, Telford and Wrekin midwife-led unit review. Phase 1 has considered a range of existing information from a number of

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different organisations. A summary of key documents considered for this review is available in Section 7 of this report.[1]

- Phase 2 (Gathering new information) which included gathering detailed information from women and their families as well as professionals working in or with maternity services.
- Phase 3 (Co-design workshops) which involved commissioners, women and their families, staff and community members with an interest in midwifery led care

1.7. The information gathered during Phase 1 and Phase 2 has been used to inform discussion in the co-design workshops in Phase 3. The proposed service model is based on the findings of Phase 1, 2 and 3.

1.8. In addition to addressing the specific requirements set for this review, the review has also considered any required service improvements in line with 'Better Births'[2] – a five year forward view for maternity care.

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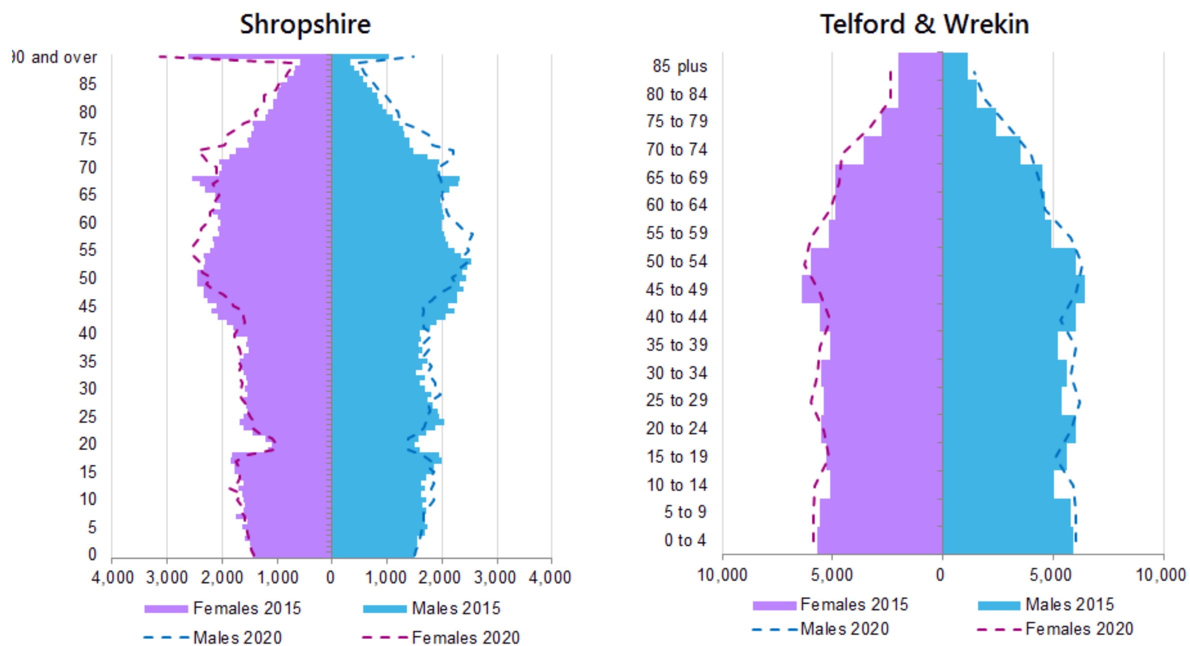
[1] Different organisations use a variety of data definitions and collection methods. As several data sources were used to inform this report, there is slight variability in some of the figures reported.
[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

**2. Context**

2.1. Local Context[3]

The overall population within Shropshire, Telford and Wrekin is approximately 480,000 people. Telford & Wrekin CCG has a large, younger urban population with some rural areas. Telford is ranked amongst the 30% most deprived populations in England. The population of approximately 170,000 is due to grow to 180,000 by 2020. Shropshire CCG covers a large rural population with problems of physical isolation and low population density. Shropshire has a mix of rural and urban areas and has an overall population of approximately 308,000 which is set to rise to 320,600 by 2020.




2.2. Just over a third of Telford and Wrekin's total female population (36%) are of child bearing age, which is similar to the national average (37%), this compares to 30% in Shropshire. Projections, based on national data, indicate that the numbers of women of childbearing age will remain relatively static in the next two decades. However, local data suggests that in Telford & Wrekin the female population aged 16-44 years will be almost 3,000 greater than the national expectations.

2.3. It is estimated that a significantly high level of adults (71%) in Telford and Wrekin carry excess weight (i.e. overweight or obese), which is significantly worse than the national average (64.8%). This equates to circa 22,250 women of child bearing age (15-44 years) in Telford and Wrekin, compared to 65.2% in Shropshire (30,900 women of child bearing age).

[3] Shropshire, Telford & Wrekin Sustainability and Transformation Plan

Overview of key routine maternal and infant population health measures January 2017 Public Health, Telford and Wrekin Council

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2.4. Maternal smoking is significantly high in Telford and Wrekin, although in the past two years smoking at the time of delivery has started to decline. The rate of smoking in pregnancy in Telford and Wrekin was 18.1% in 2015/16, compared to 12.3% in Shropshire and 10.6% in England as a whole. A total of 367 women were still smoking at delivery in 2015/16, which compares to 297 women smoking at delivery in Shropshire.

2.5. Levels of breastfeeding (both initiation at birth and duration at 6-8 weeks) have been historically low in Telford and Wrekin. Although rates have been improving slowly, almost a third (32.5%) of infants (655 babies) were not breastfed at birth, which is significantly worse than the average for England 25.7%. In Shropshire just under a quarter, 24.7% of infants (605 babies) were not breastfed at birth in 2015/16, which is similar to the national average.

2.6. There are on average 14 deaths per year of infants under 12 months in Telford and Wrekin (2013-15). The infant mortality rate (6.5 per 1,000 live births) was significantly worse than the England average between 2011 and 2015. In Shropshire there are on average nine deaths under 12 months annually, the infant mortality rate (3.1 per 1,000 live births) is not significantly different to the England average.

2.7. The number of deaths during the first 4 weeks of life (neonatal deaths) in Telford & Wrekin has been increasing slowly in recent years by one case per year. The neonatal mortality rates in Telford & Wrekin from the period 2012-14 and 2013-15 were significantly worse than the England average. In Shropshire the number of neonatal deaths remains static and rates are similar to the England average.

2.8. Overview of Key Maternal and Infant Health Measures

| | Telford & Wrekin | | Shropshire | | England |
|---|---|---|---|---|---|
| | **No.** | **% / rate** | **No.** | **% / rate** | **% / rate** |
| **Demographic & socio-economic indicators** | | | | | |
| Population: Total (2015) | 171,200 | | 311,400 | | |
| Population: 0-4 years (2015) | 11,300 | 6.6% | 15,100 | 4.8% | 6.2% |
| Population: 16-44 females (2015) | 31,300 | 36.3% | 47,400 | 30.2% | 37.1% |
| Children and young people (under 20) living in poverty (2013) | 8,690 | 22.0% | 6,970 | 12.0% | 18.0% |
| Children (under 16) in low income families (2013) | 7,760 | 23.0% | 6,180 | 12.7% | 18.6% |
| Women of childbearing age (15-44 years) living in deprived areas (2015) | 8,900 | 28.6% | 2,700 | 5.8% | 21.9% |
| **Fertility and conception rates** | | | | | |
| General fertility rate (live births per 1,000 women aged 15-44 years) (2015) | 2,075 | 64.1 | 2,795 | 56.9 | 62.5 |
| Teenage pregnancy rates (under 18 conceptions per 1,000 females aged 15-17 years) (2014) | 105 | 32.6 | 85 | 15.1 | 22.8 |
| **Maternal health and lifestyle** | | | | | |
| Excess weight in adults (2013-15) | 22,250 | 71.1% | 30,900 | 65.2% | 64.8% |
| Smoking at time of delivery | | 18.1% | 297 | 12.3% | 10.6% |

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| (2015/16) | 367 | | | | | | |
|---|---|---|---|---|---|---|---|
| Breastfeeding initiation (2014/15) | 1,361 | 67.5% | | 1,844 | 75.3% | | 74.3% |
| Breastfeeding at 6-8 weeks (2014/15) | 742 | 36.3% | | 1,272 | 45.9% | | 43.2% |
| **Infant mortality and related indicators** | | | | | | | |
| Births to mothers born outside UK (2013-15) | 990 | 16% | | 813 | 10% | | |
| Stillbirths in mothers born outside the UK (% of total stillbirths) (2013-15) | | 26% | | | 14% | | |
| Low birth weight of term babies (2014) | 46 | 2.5% | | 69 | 2.6% | | 2.9% |
| Infant mortality rate (No. of deaths under one year per 1,000 births) (2013-15) | 41 | 6.5 | | 26 | 3.1 | | 3.9 |
| Stillbirth rate (No. of stillbirths per 1,000 total births) (2013-15) | 12 | 4.3 | | 9 | 4.2 | | 4.4 |
| Perinatal mortality rate No. of stillbirths and deaths under one week per 1,000 total births (2013-2015) | | 8.1 | | | 6.0 | | 8.2 |
| Neonatal mortality rate No. deaths of under 4 weeks per 1,000 live births (2013-2015) | 10 | 4.6 | | 6 | 2.2 | | 2.7 |

2.9. National Context

NHS Hospital Episodes Data 2015-16 reports that there were 648,107 deliveries in NHS hospitals during 2015-16, an increase of 1.8 % from 2014-15. The number of deliveries for mothers aged under 20 has almost halved over the last ten years, from 43,572 deliveries in 2005-06 to 22,032 in 2015-16, whilst the number of deliveries for mothers aged 40 years and over has risen from 20,530 in 2005-06 to 24,942 in 2015-16, an increase of 21.5 %. The proportion of spontaneous deliveries has dropped from 64.8 % in 2005-06 to 60.0 % in 2015-16. Caesarean deliveries increased from 24.1 % to 27.1 % in the same period.

2.10. The national direction for maternity services was set out in the 2016 Maternity Review Report. *Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)* describes the way in which maternity services need to change. The seven key themes are outlined below.

2.11. *Personalised care.* This includes a personalised care plan for each woman, which sets out her decisions, reflects her wider health needs and is kept up to date throughout her pregnancy. It also includes women being able to access unbiased information through their own digital maternity tool, which enables them to access their own health records and information which is appropriate to them.

2.12. *Continuity of carer,* with each woman having a midwife who is part of a small team of 4-6 midwives. Each team of midwives should have an identified obstetrician. The woman's midwife should liaise closely with other professionals so that the woman's care is joined up.

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2.13. *Safer care,* with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place. Provider Boards should have a board level champion for maternity services and should promote a culture of learning and continuous improvement.

2.14. *Better postnatal and perinatal mental health care,* including significant investment in perinatal mental health services. Women should have access to their midwife and obstetrician, where appropriate, as they require after having their baby. There should be a smooth transition between services.

2.15. *Multi-professional working.* Those who work together should train together. Use of an electronic maternity record should be rolled out nationally, where the woman can share and can input the information that is important to her.

2.16. *Working across boundaries.* Community Hubs should be established where maternity services are provided alongside other services for families. Providers, Commissioners and other professionals should come together on a larger geographical area through Local Maternity Systems and Clinical Networks to work to common agreed standards and to share information, best practice and learning. Commissioners need to commission against clear outcome measures and take responsibility for improving outcomes and reducing health inequalities.

2.17. *A payment system* should be in place that is fair, incentivises efficiency and pays providers appropriately for the services they provide.

2.18. Saving Babies' Lives: A care bundle for reducing stillbirths (March 2016, NHSE) sets out the requirement to reduce stillbirths by 20% by 2020 and 50% by 2030. Saving Babies' Lives is a care bundle designed to support providers, commissioners and healthcare professionals to take action to reduce stillbirths and early neonatal death and brings together four elements of care that are recognised as evidence-based and/or best practice, these are:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

2.19. The key themes emerging from other national publications considered for this review are:

- The importance of choice and continuity of care
- The need for improvements in digital technology to support delivery of maternity services
- Outcomes-focussed commissioning
- The importance of supporting and developing the workforce
- Recognition that the risks and clinical needs of women are on the increase due to mothers giving birth later in life and an increase in other risk factors such as obesity
- The need for effective joint working between professionals, including seamless transfer between services

## 3. What we already know about the current maternity service in relation to Midwife Led Units

3.1. Overview

The table below provides a summary of the existing facilities within maternity services provided by Shrewsbury and Telford Hospitals NHS Trust.

| **Shropshire, Telford and Wrekin Maternity Services : Current Provision** |
|---|

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| Unit | Beds | Labour Rooms | Site | Comments |
|---|---|---|---|---|
| Consultant Unit Antenatal Ward | 13 | 0 | Princess Royal Hospital (Telford) | Also has:<br>- 4 triage beds<br>- a bereavement suite (labour room and living/meeting room)<br>- side room (for triage/consultations) |
| Consultant Unit Delivery Suite | 0 | 13 | Princess Royal Hospital (Telford) | Includes 1 bereavement room.<br><br>1 labour room has a pool.<br><br>Also has 2 theatres plus recovery. |
| Consultant Unit Postnatal Ward | 23 | 0 | Princess Royal Hospital (Telford) | Transitional care incorporated within. |
| Wrekin MLU | 13 | 4 | Princess Royal Hospital (Telford) | Antenatal, birth (MLU or homebirth) and postnatal care provided.<br><br>One labour room has a pool.<br><br>Additional consultation/clinical room. |
| Shrewsbury MLU | 10 | 3 | Royal Shrewsbury Hospital (Shrewsbury) | Antenatal, birth (MLU or homebirth) and postnatal care provided.<br><br>Includes day assessment unit.<br><br>One labour room has a pool. |
| Oswestry MLU | 6 | 2 | Robert Jones and Agnes Hunt Orthopaedic Hospital (Gobowen, Oswestry) | Antenatal, birth (MLU or homebirth) and postnatal care provided.<br><br>One labour room has a pool.<br><br>Additional clinic room for consultation and scans. |
| Ludlow MLU | 4 | 1 | Ludlow Community Hospital (Ludlow) | Antenatal, birth (MLU or homebirth) and postnatal care provided.<br><br>A birthing pool is available in a separate pool room. |
| Bridgnorth MLU | 4 | 2 | Bridgnorth Community Hospital (Bridgnorth) | Antenatal, birth (MLU or homebirth) and postnatal care provided.<br><br>One labour room has a pool. |
| Whitchurch Community Base | 0 | 0 | Whitchurch | Antenatal, homebirth and postnatal care provided. |
| Market Drayton Community Base | 0 | 0 | Market Drayton | Antenatal, homebirth and postnatal care provided. |

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3.2. The needs of women accessing maternity services are assessed and classified against 3 different pathways, which are defined at a national level (standard, intermediate and intense). Women with low needs are included within the standard pathways and those with the highest level of need are included within the intense pathways. The proportion of women within each of the different pathways in 2016/17 in Shropshire, Telford and Wrekin is provided in the table below and includes a comparison to other areas.

| | | **Number (%) Women** | | |
|---|---|---|---|---|
| **Stage of Pregnancy** | **Level of Need** | **Shropshire** | **Telford & Wrekin** | **West Midlands CCGs 2015/16[4]** |
| Antenatal | Standard | 1450 (51%) | 892 (39%) | 49.2% |
| | Intermediate | 1134 (40%) | 1147 (51%) | 41.8% |
| | Intense | 264 (9%) | 220 (10%) | 9% |
| Delivery | Without complications/co-morbidities | 2133 (80%) | 1720 (78%) | - |
| | With complications/co-morbidities | 528 (20%) | 473 (22%) | - |
| Postnatal | Standard | 1643 (63.4%) | 1097 (55.8%) | 70.6% |
| | Intermediate | 940 (36.3%) | 860 (43.7%) | 28% |
| | Intense | 7 (0.3%) | 9 (0.5%) | 1.4% |

3.3. Performance against quality indicators for maternity in 2016/17 was within the expected range and in line with national performance. However, there are a number of indicators for which performance is worse than the expected range. Indicators that were not within the expected range are given in the table below:

| **Descriptor** | **Lower Limit** | **Expected Figure:** N = National Target, S = Birth Rate Plus Target, A = LSA Target, L = Locally agreed expected figure, B = Nationally Benchmarked | **Upper Limit** | **2016/17** | **2015/16** |
|---|---|---|---|---|---|
| % of births in Consultant Unit | 70% | 75-85% (L) | 90% | **85.1%** | **82.3%** |
| % of births in any MLU | 10% | 15-25% (L) | 30% | **14.4%** | **17.4%** |

[4] Sandwell and West Birmingham CCG, Birmingham Cross City CCG, Birmingham South and Central CCG, Walsall CCG, Dudley CCG, Stoke on Trent CCG, Wolverhampton CCG, Shropshire CCG, Telford and Wrekin CCG, Solihull CCG, South East Staffordshire and Seisdon Peninsula CCG, North Staffordshire CCG, East Staffordshire CCG, Cannock Chase CCG, Stafford and Surrounds CCG.



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| % of births in a MLU or at home | 10% | 15-25% (L) | 30% | **13.1%** | **16.1%** |
|---|---|---|---|---|---|
| Overall Assisted Births rate % | | <10% (L) | 25% | **10.2%** | **9.8%** |
| Caesarean Section rate % | | <20% (L) | 25% | **20.5%** | **19.4%** |
| Induction Rate % | 15% | 25-30% (L) | 40% | **31.7%** | **30.7%** |
| % of bookings with a gestation of less than 12 weeks 6 days | 85% | >90% (N) | | **88.7%** | **91.7%** |
| % patients delivered who received 1:1 care during established labour | 95% | 100% | | **97.5%** | **97.7%** |

3.4. Analysis of performance to date in 2017/18 shows performance against the vast majority of quality indicators to be within the expected range.

3.5. Several reviews are ongoing at the time of writing this report in relation to the level of potential avoidable deaths within SaTH maternity services. The content of these review reports, once available will be considered in relation to the review of midwife led units in order to ensure the recommendations from this review are in line with any recommendations from other reviews currently taking place.

3.6. In general, midwife led units enable care to be provided close to home with many women living within 20 minutes (by car) of a midwife led unit. For some, access to the consultant led unit at Princess Royal Hospital is a longer journey with those in the far South West of the county experiencing journey times of up to an hour or more.

3.7. Care before the baby is born (Antenatal Care)
Women can book to receive maternity services through their GP or by booking with maternity services directly. Around 5,500 women book to receive maternity services at SATH each year.

3.8. The majority of antenatal care is delivered by community midwives. Rural community teams regularly have between 300-400 attendances a month. Wrekin and Shrewsbury community teams have around 2,500 and 1,200 attendances a month respectively. The clinics in Whitchurch and Market Drayton each have around 200 attendances a month.

3.9. Women can access antenatal care at a midwife led unit, one of the two community bases, a clinic at their GP practice or through the midwife visiting them at home. For those women who are considered high risk, they can access obstetric care through clinics at Princess Royal Hospital, Royal Shrewsbury Hospital or the hospital at which they plan to have their baby. There are also obstetric clinics held in Ludlow and Oswestry MLUs. All women have access to midwife advice over the telephone 24 hours a day, 7 days a week.

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3.10. All women are routinely offered between 9 and 15 antenatal appointments throughout their pregnancy, dependent on their level of risk and term of pregnancy. At least one of these appointments will be in the woman's home. Women may have more appointments than this.

3.11. Women don't always see the same midwife throughout all of their care. However, community midwives mostly work in small teams with many GP practices having an allocated midwife, so women are likely to know the midwife they see during their pregnancy. Women are less likely to know the midwife caring for them when they give birth to their baby.

3.12. For antenatal maternal and fetal monitoring, women can access services at each of the MLUs as well as at the consultant unit. Pregnancy scans are offered at Royal Shrewsbury Hospital, Princess Royal Hospital, Oswestry MLU, Bridgnorth MLU or the hospital at which the woman plans to have her baby.

3.13. Giving Birth (Intrapartum Care)[5]
Women have a range of options in relation to where they give birth in Shropshire, Telford and Wrekin. These are:
- Consultant Unit (CU)
- Along-side MLU (on same site as consultant unit)
- Freestanding MLU (not on the same site as consultant unit)
- Home birth

3.14. SATH maternity services have around 5,000 births each year. Over 92% births are in relation to Shropshire, Telford and Wrekin patients. The remaining births are made up of Powys patients (4.4%) and patients from other areas (3.2% - mostly Staffordshire and Wolverhampton). The activity for 2016/17 is summarised in the table below. In 2016/17, 16 women from Telford & Wrekin and 152 women from Shropshire gave birth in other hospitals in England. Some women from Shropshire access services in Wales at Wrexham Maelor Hospital. In 2016/17 137 Shropshire Women accessed inpatient maternity services at Wrexham Maelor Hospital, this includes 106 deliveries. In England, the most common areas outside of Shropshire, Telford and Wrekin in which Shropshire, Telford and Wrekin women give birth are Birmingham, Wolverhampton, Chester, Cheshire, Staffordshire, Worcestershire and Wye Valley. Shropshire women give birth in a much greater range of hospitals than Telford and Wrekin women.

3.15. The number of babies born in Shropshire, Telford and Wrekin is summarised in the table below.

| **SATH Maternity Services : Births 2016/17** | | | | |
|---|---|---|---|---|
| **Maternity Unit** | **Shropshire Patients** | **Telford & Wrekin Patients** | **Powys Patients** | **Patients from other areas** |
| Consultant Unit | 2,016 | 1,830 | 216 | 132 |
| Shrewsbury MLU | 142 | 0 | 0 | 0 |
| Wrekin MLU | 135 | 199 | 0 | 3 |
| Bridgnorth MLU | 67 | 2 | 0 | 8 |
| Oswestry MLU | 50 | 0 | 0 | 2 |
| Ludlow MLU | 31 | 0 | 0 | 5 |

[5] Where numbers are given for 'births', this is the number of babies born. Where numbers are given for 'deliveries' this is the number of women who have given birth e.g. if a woman has twins, this will be one delivery but two births.



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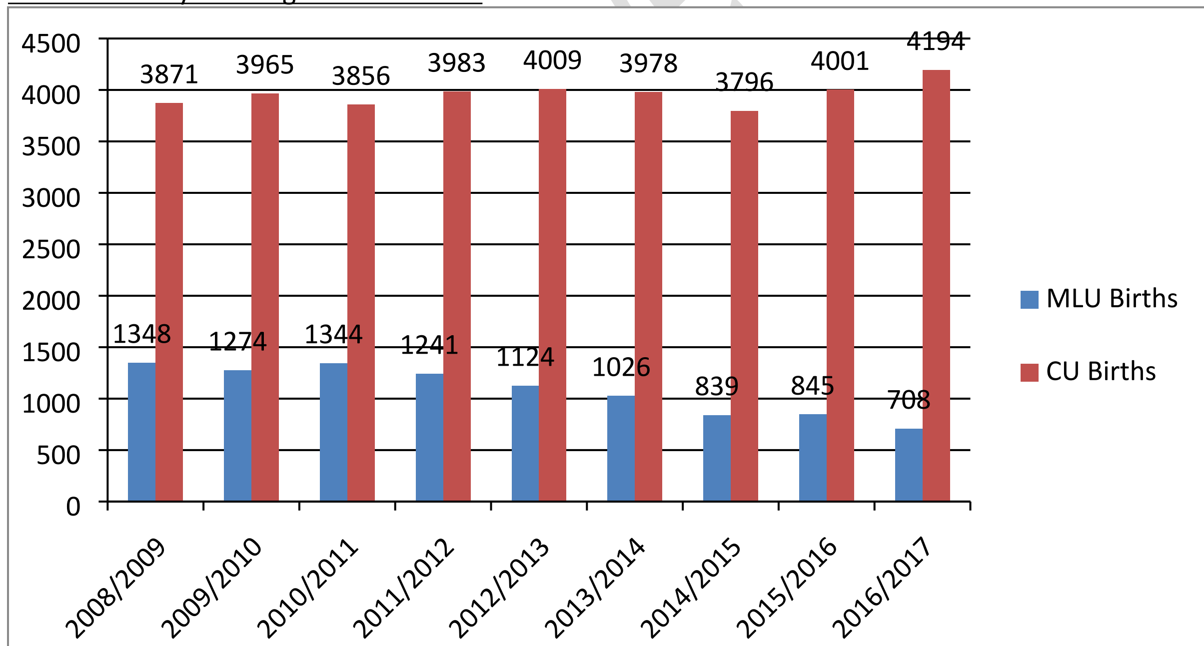
| Home | 41 | 21 | 1 | 1 |
|---|---|---|---|---|
| Born before arrival (without presence of midwife or obstetrician)/other | 8 | 8 | 2 | 8 |
| **Total** | **2,490** | **2,061** | **219** | **158** |
| **Total Births 2016/17** | **4,928** | | | |

3.16. For women registered with a GP in the north of Shropshire, in 2016/17 73.9% had their baby in Princess Royal Hospital, 12.2% had their baby in Wrexham Maelor and 5.8% had their baby in Oswestry MLU. A higher percentage of women registered with a GP in Shrewsbury and surrounding areas gave birth at Princess Royal Hospital (87.9%) with the remainder giving birth at Shrewsbury MLU (11.6%). 5 women from Shrewsbury and the surrounding areas gave birth further afield. Most of the women registered with a South Shropshire GP practice gave birth at Princess Royal Hospital (71.6%). 9.3% gave birth in Bridgnorth MLU, 4.5% had their babies at Ludlow MLU. The remainder gave birth out of county with most going to Worcestershire Royal Hospital (5.7%) and Hereford County Hospital (4.6%). Other places of birth for people registered with a GP in the south include Shrewsbury, Wrexham, Stoke, Wolverhampton and Birmingham.

3.17. Over the last nine years, the births within the midwife-led units or at home on the whole have declined from approximately 1350 (26% of total activity) to 708 (14% of total activity), as illustrated in the graph below.

SATH Summary Birth Figures 2008-2017




3.18. Of the women accessing SATH maternity services, 85.1% give birth in the Consultant Unit. This is in line with the findings of the national maternity review[6] (87% women nationally give birth in a consultant led unit). 13.1% give birth in a MLU with 3.3% of these women giving birth in one of the smaller MLUs in either Oswestry, Bridgnorth or Ludlow. 1.3% of women have home births. The remainder of births (0.5%) are born before arrival (BBA). This means the baby was born without a midwife or obstetrician being there.

[6] Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)

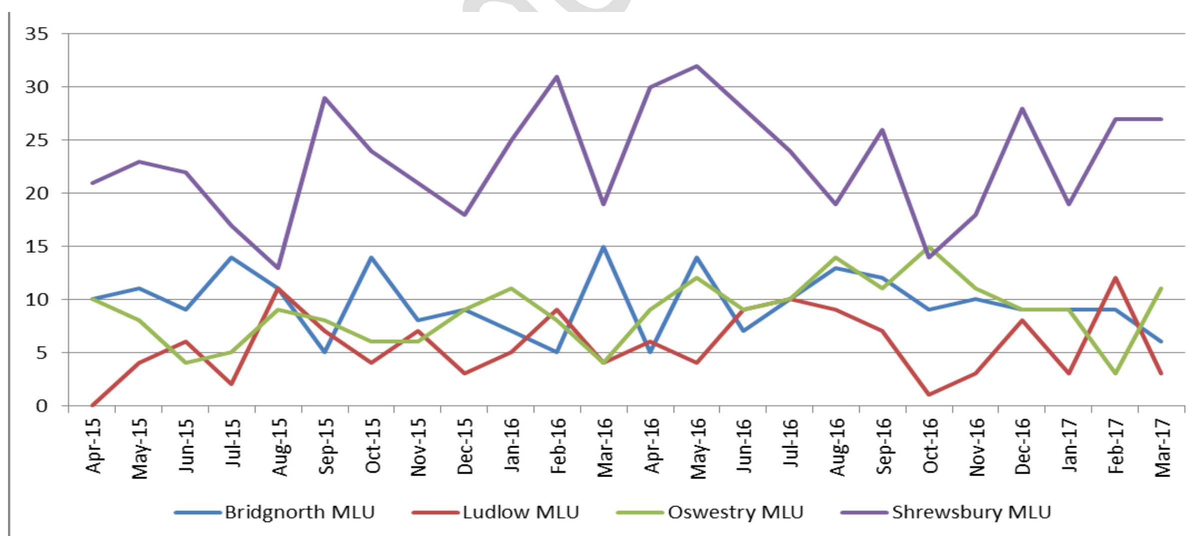
3.19. In Shropshire, Telford & Wrekin, many women intend to give birth at midwife led units, but go on to deliver in the consultant unit. In 2015 and 2016, 3,921 women intended to give birth in a MLU or at home. However, only 1,498 (38.2%) of women who intended to give birth in a MLU or at home actually did so. This compares to deliveries in the consultant unit in 2015 and 2016 where 95% of women who intended to give birth in the consultant unit (4,994), did so. The change of intended place of delivery most commonly occurs during the antenatal period and is usually associated with a change in risk to the mother or the baby.

3.20. A proportion of women start delivery at a MLU and are then transferred to a consultant unit. In 2015 and 2016, 723 women started their delivery at one of the MLUs but then transferred to the consultant unit for the birth of their baby.

3.21. Care after the baby is born (Postnatal care)

3.22. Most women (90%) and their babies who access inpatient postnatal care do so on either the Postnatal Care Ward at Princess Royal Hospital, the Wrekin MLU or Shrewsbury MLU. 10% of women receive some or all of their inpatient postnatal care at either Ludlow, Bridgnorth or Oswestry MLU.

3.23. In 2016/17 the MLUs cared for around 2,074 women postnatally who delivered their babies in the consultant led unit. The majority of these women were cared for postnatally at Wrekin MLU (1,406). Shrewsbury cared for 331 women postnatally, with Ludlow, Oswestry and Bridgnorth caring for 91, 106 and 140 women respectively. The Graph below shows the number of women who had a postnatal stay in one of the freestanding MLUs after giving birth in the consultant led unit from April 2015 – March 2017. The alongside MLU (Wrekin) cares postnatally for a much higher number of women who delivered their babies at the consultant led unit (around 80-118 per month).




3.24. On average women who have a postnatal stay, stay at the MLUs for around two and a half days. The number of women having a postnatal stay varies across the MLUs. In 2016/17 the MLUs each had between approximately 5 and 15 women each month having a postnatal stay. This doesn't include Wrekin MLU, which has a higher number of women staying each month.

3.25. The table below shows the total bed days available at the MLUs compared to the bed days used in 2016/17.[7]

| MLU | Total bed days available per year | Total bed days used 2016/17 (% utilisation) |
|---|---|---|
| Wrekin | 13 x 365 = 4,745 | Not available[8] |
| Shrewsbury | 10 x 365 = 3,650 | 647 (18%) |
| Bridgnorth | 4 x 365 = 1,460 | 321 (22%) |
| Oswestry | 6 x 365 = 2,190 | 570 (26%) |
| Ludlow | 4 x 365 = 1,460 | 239 (16%) |

3.26. Women and their babies are cared for by a midwife until the baby is 10 days old. Women are offered a minimum of two visits from a midwife at home after they've had their baby. The first will happen the day after they leave hospital/MLU. They will also have a visit 5 days after they go home. Some women may have more visits from a midwife.

3.27. After 10 days, the care is handed over to the health visiting service. The health visiting services in Shropshire, Telford and Wrekin are commissioned by Shropshire Council and Telford and Wrekin Council. Health visiting services across Shropshire, Telford and Wrekin are provided by Shropshire Community Health NHS Trust. The health visiting service will support the family until the child is 5 years old. Midwives use written information to handover care to the health visiting service. This is through recording information in the 'red book', which is left with women to share with the health visitor. In more complex cases, there may be more in-depth communication between the midwife and health visitor in handing over the care.

3.28. Workforce

3.29. SaTH employ a range of staff to deliver the maternity service. SaTH do not use any agency midwives to deliver the maternity service. The total staffing establishment is 270.09 whole time equivalent (WTE) and summarised in the table below (note: WSA = Women's Support Assistant):

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[7] For example : One bed day = one woman staying overnight. Two bed days could be one woman staying for two nights, or two women each staying for one night. If all of the beds were used all of the time, the utilisation would be 100%.

[8] Data is currently recorded by site. Information about postnatal stays specifically in the MLU was not available at the time of writing this report, as information relating to Princess Royal Hospital includes activity in the consultant unit as well as the MLU.

| Staff | WTE |
|---|---|
| Midwives | 153.78 WTE |
| WSA’s | 79.79 WTE |
| Assurance/Patient Experience | 3.0 WTE |
| Information Team | 2.2WTE |
| Specialist Midwives | 7.6 WTE |
| Ultrasound Midwives | 11.72WTE |
| Managers | 12.0WTE<br>(of which 3.2 WTE clinical) |

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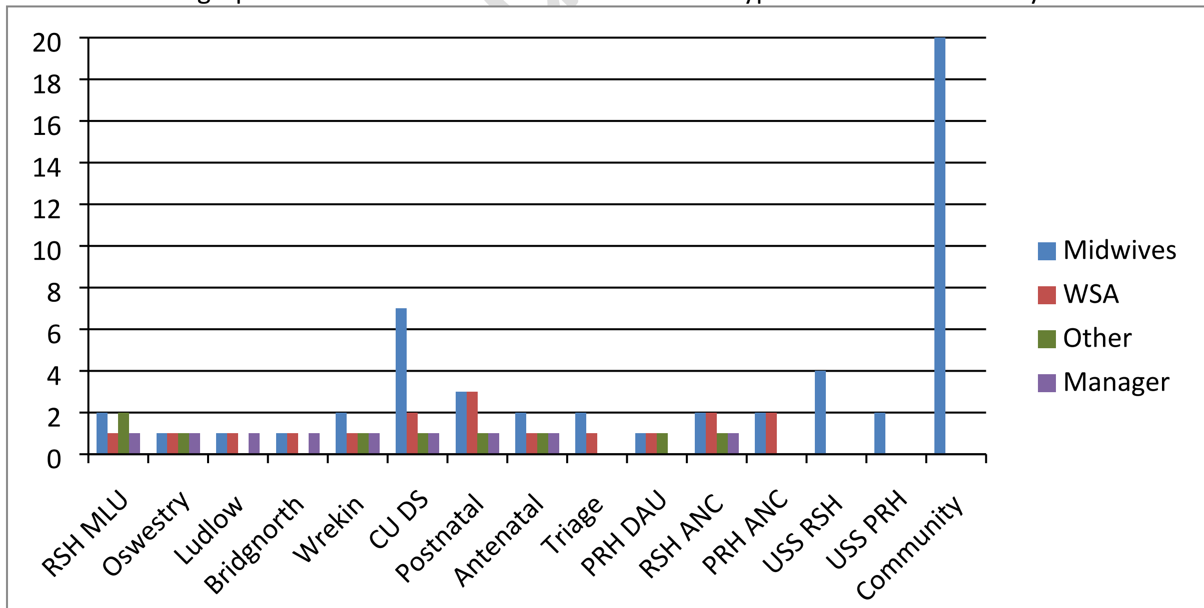
3.30. As well as a lead midwife for the consultant unit and a lead midwife for community and MLUs, the service also has a number of specialist midwife roles, including:

- Bereavement
- Improving women’s health (vulnerable women)
- Feeding
- Safeguarding
- Information Systems
- Guidelines
- Screening
- Education
- Public Health

3.31. Units are staffed with a mix of midwives, women’s support assistants (WSA), managers and ward clerks. The graph below shows the number and type of staff on duty at a time.




Key : RSH MLU = Shrewsbury Midwife Led Unit
CU DS = Consultant Unit Delivery Suite
Postnatal = Consultant Unit Postnatal Ward
Antenatal = Consultant Unit Antenatal Ward
PRH DAU = Princess Royal Hospital Day Assessment Unit

RSH ANC = Royal Shrewsbury Hospital Antenatal Clinic
PRH ANC = Princess Royal Hospital Antenatal Clinic
USS RSH = Scanning at Royal Shrewsbury Hospital
USS PRH = Scanning at Princess Royal Hospital
Community = Midwives seeing women in the community

3.32. Midwives staff each of the units through shift and on-call arrangements. The current arrangements are detailed in the table below.

| **Midwife staffing arrangements** | | | |
|---|---|---|---|
| **Unit** | | **Shift** | **On call** |
| Consultant Led Unit | Delivery Suite | 7 | 0 |
| | Antenatal Ward | 2 | 0 |
| | Postnatal Ward | 3 | 0 |
| MLU | Wrekin | 2 | 1 |
| | Shrewsbury | 1 | 1 |
| | Bridgnorth | 1 | 1 |
| | Oswestry | 1 | 1 |
| | Ludlow | 1 | 1 |
| **Total** | | **18** | **5** |

3.33. A Birthrate Plus report was produced for SaTH in April 2017. Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making. The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus.

3.34. The BR+ report produced for SaTH maternity services suggests that an overall increase in staffing is required, but that the smaller MLUs are over-staffed for the level of activity. The BR+ recommended increase in staffing is detailed in the table below:

| | **BR+ recommended WTE** | **Current WTE** | **Variance** |
|---|---|---|---|
| **Consultant Unit** | 101.21 | 85.65 | -15.56 |
| **Wrekin MLU** | 44.70 | 31.15 | -13.55 |
| **Shrewsbury MLU** | 25.96 | 20.30 | -5.66 |
| **Ludlow MLU** | 4.17 | 7.89 | 3.72 |
| **Oswestry MLU** | 6.93 | 8.20 | 1.27 |
| **Bridgnorth MLU** | 5.96 | 8.45 | 2.49 |
| **Whitchurch and Market Drayton bases** | 6.26 | 4.94 | -1.32 |
| **TOTAL** | **195.2** | **166.58**[9] | **-28.61** |

3.35. BR+ states that for the MLUs and community bases, the shortfall of 13.06wte are not just midwives and a significant number can be appropriately qualified maternity support workers (MSW) assisting with postnatal care in the MLUs and community. Maternity support workers are the same type of

[9] Not including, Women's Support Assistants, Ultrasound Midwives or Managers



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role as Women's Support Assistants. An estimated 10.66wte could be MSWs across the total community, reducing the midwifery shortfall to 2.40wte. For the consultant-led unit, an estimated 6.0wte could be appropriately qualified maternity support workers, reducing the midwifery shortfall in the consultant led unit to 9.56wte.

3.36. Historically, sickness and absence rates relating to maternity staff have been low. However, in recent months absence rates have increased which have put further pressure on services. This has led to the provider taking action to implement interim arrangements to ensure maternity services continue to be safe. The interim arrangements involve reducing the service at midwife led units, so that inpatient births and inpatient postnatal stays are not available at three of the smaller midwife led units.

3.37. Information and Record Keeping
Women have handwritten hand held notes, which they take with them to all appointments relating to their care during pregnancy. SaTH also hold handwritten hospital notes, to document any care provided in a hospital setting. The main information system used for electronically recording maternity care is 'Medway'. However, due to connectivity issues in the rural MLUs and community bases, it is not consistently available in all community settings currently used for maternity care.

3.38. SATH had previously sought to implement electronic record keeping in the community through digital pens. However, the project was not able to proceed as the provider was not confident in the accuracy/reliability of information being transferred onto Medway. It was not considered clinically safe to implement.

3.39. Further rollout of the Medway system is taking place in October/November 2017 and this will include more elements of activity also being recorded on Medway. SATH aspire to having all community antenatal and postnatal activity being recorded on Medway. However, this is not possible at this stage due to connectivity issues across the county.

3.40. Newborn physical examinations are currently recorded on Medway but due to a national requirement the NIPE examination will be recorded on NIPE SMART by Q3 2017. There are concerns that this fragmentation of information (i.e. that it is not recorded on Medway) may have associated risks. These are being considered by SaTH.

3.41. Finance
Maternity services are funded by a tariff (maternity pathway payment), which is set nationally. SaTH receive payment according to the number of women they have cared for at each stage of their pregnancy. The amount received will also depend on how high each woman's need is. The maternity pathway payment system splits maternity care into three stages: antenatal, delivery and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care, the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need.

3.42. The amounts paid to the provider for each woman are summarised in the table below.

| **Maternity Pathway Payment** | | |
|---|---|---|
| Stage of Pregnancy | Level of Need | £ per woman |
| Antenatal | Standard | 1,108 |
| | Intermediate | 1,629 |
| | Intense | 2,711 |
| Delivery | Without complications/co- | 1,819 |

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|  |  |  |
|---|---|---|
|  | morbidities |  |
|  | With complications/co-morbidities | 3,120 |
| Postnatal | Standard | 248 |
|  | Intermediate | 313 |
|  | Intense | 842 |

3.43. SaTH identifies a cost pressure of around £1m which relates to Midwifery Led Units. However, as MLUs are operating as part of a much wider service/set of services, there are lots of other factors that affect the income and cost.

3.44. The biggest cost for MLUs is staffing. Therefore, it is important that this review considers how to ensure the staffing element is as efficient and effective as possible in order to get best value. It will be important to consider what skills are likely to be required during the day/night and in what volume. The current service configuration doesn't best meet demand. For example, at night each of the smaller MLUs has a midwife on site at the unit. This is the case whether there are women staying in the unit or not. However, at night the highest demand for midwives is in the consultant led unit, where currently they often have a shortage of midwives overnight.

3.45. A significant cost pressure relating to maternity services, including MLUs is in relation to the Clinical Negligence Scheme for Trusts (CNST). This is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme. For SaTH maternity services as a whole, the cost of this is nearly £5.8million per year.

3.46. Bridgnorth, Ludlow and Oswestry MLUs are sited in buildings not owned by SaTH. Therefore, there are additional costs associated with rent for these units.

3.47. The table below shows how many women from Shropshire, Telford & Wrekin (in 2016/17) received care within each of the different pathways. It also shows the total amount the Shropshire, Telford and Wrekin CCGs spent in 2016/17 relating to each of the pathways.

|  | **Maternity Pathway Payment 2016/17** |  |  |  |  |
|---|---|---|---|---|---|
| Stage of Pregnancy | Level of Need | Number of women |  | Total Spend |  |
|  |  | Shropshire CCG | Telford & Wrekin CCG | Shropshire CCG | Telford & Wrekin CCG |
| Antenatal | Standard | 1450 | 892 | £1,573,250 | £967,820 |
|  | Intermediate | 1134 | 1147 | £1,967,490 | £1,990,045 |
|  | Intense | 264 | 220 | £762,696 | £635,580 |
| Delivery | Without complications/co-morbidities | 2133 | 1720 | £3,914,851 | £3,151,756 |
|  | With complications/co-morbidities | 528 | 473 | £1,432,716 | £1,282,870 |



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| Postnatal | Standard | 1643 | 1097 | £422,251 | £281,929 |
|---|---|---|---|---|---|
| | Intermediate | 940 | 860 | £303,620 | £277,780 |
| | Intense | 7 | 9 | £6,090 | £7,830 |

**4. What patients have said about the current Midwife Led Units**

4.1. The majority of engagement for this review has been undertaken in Phase 2, using an 'Experience Led Commissioning' approach. This involves working in partnership with women who have used services to design the future model of service. It also gathered feedback from professionals and others with an interest in Shropshire, Telford and Wrekin midwife led units.

4.2. For Phase 1 of the review the following sources of existing patient feedback have been used:

- Shropshire maternity services usage – survey by MLU campaign group (2017) (Analysis of results by campaign group and analysis of results by Healthwatch Shropshire have been used)
- Feedback from patients received by SaTH
- Feedback from patients received by Healthwatch Shropshire October 2016-May 2017
- Feedback from patients received by Healthwatch Telford & Wrekin July 2016-June 2017
- CQC survey of women's experiences of maternity services at SaTH (2015)

4.3. The majority of feedback received from patients in relation to MLUs is positive.

4.4. In feedback to Healthwatch, women and their partners report positively in particular with regards to support provided postnatally with breastfeeding, confidence building and emotional support. Other positive feedback is in relation to the fact that services are close to home, women know the midwives and the environment in midwife led units is welcoming and relaxing. The negative comments received included those in relation to reduced access to services at midwife led units due to staff shortages and refurbishments.

4.5. The Shropshire maternity services usage survey identified that distance from home and continuity of carer are very important to women when choosing where to give birth. Women identified in-patient postnatal care as being very important to them in the Shropshire maternity services usage survey, with the top 3 reasons for women wanting a postnatal stay being; rest and recuperation, in order to establish breastfeeding and help and support to care for the new baby.

4.6. The results of the CQC survey about the whole of maternity services show that SaTH perform about the same or better than other trusts surveyed in relation to how positive patients reported about the service received, with most areas showing no statistically significant change in response compared to the same survey undertaken in 2013.

**5. Key Findings and Considerations : Phase 1**

5.1. The findings from Phase 1 have provided some evidence towards supporting a position in relation to each of the elements this review was set to consider. A summary of Phase 1 findings is provided below:

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5.1.1. Is the clinical model of delivery currently in place in Shropshire, Telford and Wrekin clinically sustainable? Is the staffing of the units appropriate for the requirements and is there a clear workforce plan to support service delivery?

*The findings of Birthrate Plus suggest that an increase in staffing is required in order for the current service to be sustainable. Recent increases in staff absences have increased the fragility of the service. The findings of the review so far suggest that the skills of existing staff aren't being utilised in the most efficient way. Women giving birth in consultant led units don't always get 1:1 care in labour, whereas women giving birth in midwife led units or at home have at least 1:1 care in labour (unless in exceptional circumstances, their baby is born without the presence of a midwife or obstetrician). There are other models of care which may offer greater sustainability and need to be considered.*

5.1.2. Is the safety of, and are the clinical outcomes from, the current model acceptable for Shropshire, Telford and Wrekin patients? Are there any quality concerns relating to the service?

*The CCG Clinical Quality and Review processes consider the safety and clinical outcomes from the current model to be acceptable. However, the outcomes and recommendations from wider reviews will need to be considered, once published. In addition, consideration needs to be given to how the current performance around safety and clinical outcomes can be further improved, as well as how midwifery services can work with other wider services, such as those commissioned by the Local Authority to further improve longer term outcomes for women and their families.*

5.1.3. Are there any concerns relating to rural access to the services?

*Antenatal and either community or inpatient post-natal care is delivered within women's communities, but there is some geographical variability with regards to the local offer, and this is something that might be improved by consideration of alternative models of care.*
*Any new model would need to reflect the need for all service users in Shropshire, Telford and Wrekin to have a consistent, accessible service, recognising the long travel times some rural populations face if they need to travel for Consultant –led care under the current system.*

5.1.4. Are the MLUs financially sustainable?

*SaTH report that MLUs cost £1million more to run than the income they receive from the maternity tariff for the midwife led units. Hence in their current form, the MLUs are not financially sustainable for SATH. Finance alone should not be a driver for this review however, rather, the review should look at how to get the services working as efficiently as possible, to get best use of funds, staff and assets with the main drive being clinical sustainability, right care, and best value.*

*The CCG is not in a position to pay any more than tariff for maternity services and therefore supports efforts to remodel services that will drive cost out for SATH whilst improving clinical sustainability.*

5.1.5. Does the current model provide value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability?

*Information gathered to date demonstrates the need to explore different service configurations that offer appropriate rural access, improved clinical outcomes, safety, and clinical sustainability alongside better value for money. This will involve ensuring that systems are as efficient as possible*

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*and ensuring that staff expertise is utilised in the most effective way. In addition, better integration with other services would help to deliver an improvement in longer term outcomes for women and their families.*

5.2. Phase 1 of the review has identified a number of other further considerations that need to be taken account of in developing a model for future services. These are detailed below.

5.3. Population numbers in Shropshire, Telford and Wrekin are increasing. Although national projections indicate the numbers of women of a child bearing age will be relatively static over the next two decades, local projections suggest the numbers may be higher. Rates of excess weight and smoking in pregnancy are higher in Shropshire, Telford and Wrekin than the national average. In Telford and Wrekin, rates are significantly higher. Neonatal mortality rates in Telford and Wrekin are significantly higher than the national average.

*Consideration: How can the future model of service best meet these increasing needs of women and continue to offer choice?*

5.4. Women in Shropshire, Telford and Wrekin have a choice of maternity provision, which is in line with Better Births. Women receive some maternity services close to home. Most women in Shropshire, Telford and Wrekin receive antenatal care from midwives they know, close to where they live, but deliver their baby in the Consultant Led Unit at Princess Royal Hospital where they often don't know the midwives. Some of these women want to give birth at a midwife led unit, but an increased clinical risk meant that they delivered their baby at the consultant led unit instead. The proportion of births at midwife led units is decreasing. The proportion of births at the consultant led unit is increasing, but is currently in line with national figures.

*Consideration: Is there a way of enabling more women who want to have a midwife-led birth to do so?*

*Consideration: How can we increase the number of women who know the midwife who is delivering their baby and providing their postnatal care?*

5.5. In general, quality indicators relating to the maternity service show that the quality of the service is at a level that the CCG require. However, a number of reviews are underway and the recommendations of these will need to be considered, once published.

*Consideration: How can the future model of services help in delivering the recommendations of wider local reviews?*

5.6. The maternity workforce is fragile. A recent Birthrate Plus report indicates that an overall increase in the number of maternity staff, including midwives is required, but that the smaller MLUs are over-staffed for the level of activity. Sickness and absence rates within maternity services have increased in recent months; So much so, that the combined factors of fewer staff and increased demand for the consultant unit has led to the provider taking action to re-distribute staff across the service. This has meant that a reduced service is currently being delivered within the smaller midwife led units, with the units being closed for inpatient births and postnatal stays. Community visits and home births are still available.

*Consideration: How can the skill mix of staff be improved to ensure that the midwives are supported by others to enable midwives to focus their time on activity that they are especially trained to do?*

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*Consideration: What can be done to ensure that staff with the right skills are in the right place at the right time?*

5.7. Information systems and record keeping processes are time consuming and there is duplication. The provider is introducing more electronic ways of working, including electronic patient records, but these aren't yet in place.

*Consideration: How can the future model of service include effective electronic information, both for women, their families and professionals working in or with maternity services?*

5.8. The provider is reporting that the current model of provision is not financially sustainable.

*Consideration: The review acknowledges the £1m cost pressure referenced by the trust for MLU services in their current form. How can the future model of services be as efficient as possible, work to get best use of funds, staff and assets?*

5.9. Women and their families value the services provided by the midwife led units. They report positively about having services close to home with midwives that they know. Women feel that the units are welcoming and calming. Postnatal care provided by the midwife led units is regarded highly, particularly in relation to breastfeeding, emotional support and confidence building.

*Consideration: What can be done to retain/build on the elements of service delivery that women and their families most value?*

# Phase 2 : Gathering new information

## 6. Gathering new information from women and their families and professionals about Midwife Led Units

6.1. Phase 2 of the review gathered in-depth information from women and their families who have accessed services as well as professionals working in or with maternity services. The information gathered was about their experiences of receiving or delivering maternity services. Phase 2 also offered an opportunity for others who have an interest in midwife led units to feed in their views.

6.2. An external organisation specialising in co-production (ELC Works[10]) was commissioned to lead Phase 2.

6.3. Information included in this report with regards to the findings from Phase 2 is taken from the detailed reports produced by ELC works.

6.4. Phase 2 included a series of in-depth interviews with women and their families and staff working in or with maternity services. A total of 132 parents with a child aged two or under participated in this phase of the programme. 108 lived in rural settings and 24 in urban settings. In addition, a further 37 families submitted evidence by email or in writing to the researchers. This was analysed separately and has been triangulated with formal research findings.

[10] http://elcworks.co.uk/

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6.5. A total of 85 staff participated in the programme of in-depth interviews. The table below summarises their roles. 54 of the participants work in urban settings (MLU or consultant led unit) and 31 in rural settings (MLU or other community based). 40 participants work mainly in MLUs and 14 mainly in the consultant led unit. 27 work mainly in other settings.

| Roles of staff participating in research | |
|---|---|
| **Role** | **Number of participants** |
| Early pregnancy assessment service (EPAS) staff | 0 |
| Midwives | 56 |
| Women's care assistants (health care assistants) | 10 |
| Health visitors | 1 |
| GPs | 5 |
| Obstetricians | 4 |
| Special care baby unit (SCBU) staff | 1 |
| Childrens hospice nurse | 1 |
| Breast feeding volunteer | 1 |
| Housekeeper | 3 |
| Clinical manager | 2 |
| **TOTAL** | **84** |

6.6. The in-depth interviews found that family experiences across rural and urban areas are largely similar apart from birth and postnatal care where there are differences. The early days of pregnancy are characterized by a mix of emotions. Amongst those where nothing unexpected happens, emotions are often positive – even if the pregnancy is unplanned – although women may still feel anxious and overwhelmed. Where women require investigation or additional help and support early in pregnancy, some report feeling patronised. Families also report GPs being unhelpful. Relationships with clinicians – mainly midwives – are generally very positive. Some families report consultants being abrupt and 'scaremongering' them; although others report positive relationships with consultants. Generally experiences of planning and preparing for birth – including planned antenatal care are positive; with staff described as helpful, thorough and reassuring and appointments generally on time.

6.7. Those who work report antenatal care being a bit of a 'juggling act' and a few women mention getting mixed messages from staff. Generally, birth itself is regarded as a positive experience; although for some it is traumatic – especially when unexpected things happen. Those based in urban settings do not mention any challenges around reaching their place of birth nor anxiety linked to that. However, for this group, postnatal care (in the consultant led unit) is a far less positive experience, with wards described as busy and chaotic; the experience 'too clinical' and women feeling isolated and 'pushed out' of the ward as soon as possible. Women do not blame postnatal ward staff for this. They feel it is system/resource rather than a relationship problem.

6.8. Experiences of women in rural areas largely mirror those in urban areas with the exception of birth and postnatal care. Women in rural areas have the added anxiety and pain that comes from traveling a distance to hospital in labour. After birth, both groups report significant negative impact on their physical and emotional wellbeing. Those who feel unprepared for this – because they had less proactive antenatal care or missed out on classes – report that being unprepared can make it worse. The rural cohort had generally experienced postnatal care in an MLU and their experiences were extremely positive, with MLU postnatal care described as exceptional; peaceful; relaxing;

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reassuring and a 'sanctuary'. Mum friends were important and a great source of support in both rural and urban communities. It is clear from this discovery work that having well developed networks of mum friends is protective and supports recovery from birth; smooths the transition to family life; builds parental resilience and helps new mums cope and keep well. Often antenatal and postnatal care facilitate connection and making mum friends – who often become friends for life. Becoming a family is generally a positive experience; although for some it is a shock and they feel nervous.

6.9. For staff, the journey is full of ups and downs currently. Whilst they enjoy good relationships with families and this is a highlight of their work, and they feel very supported by their immediate team and colleagues – a fact that is maintaining their personal resilience in the face of significant change and challenge within the provider Trust and the maternity service more broadly - relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported by management. This is more pronounced amongst staff based in MLUs and the community than those who work solely in the consultant led unit.

6.10. Staff report that antenatal and postnatal care are now very time pressured, and whilst in the past they delivered great family centred care, they feel this is changing as a result of changes made to the service. Birth is still a high point for most; although the unpredictable nature of birth; unrealistic expectations and a sense of being under-resourced get in the way. Whilst some staff have maintained a sense of control over their working lives, many feel they have no voice and no control at all. This is undoubtedly impacting on their emotional wellbeing and resilience. It is the underlying driver for staff reporting they wish to leave their jobs. It also helps explain high rates of absenteeism and sickness, which the picture this data paints suggests may be manifesting currently.

6.11. Based on participants feedback, the characteristics that participants feel make up good maternity care in Shropshire, Telford and Wrekin are presented as fifteen "design principles" below:

1. The system focus is towards "becoming a family", with great antenatal and postnatal care valued alongside safe births
2. Staff understanding of the impact of unexpected things on women early in pregnancy and of miscarriage should be an always event
3. Relationship centred system design including continuity of care and supporting midwives to work in small teams is a really valuable aspect of our current maternity service that this maternity system needs to preserve
4. Our maternity service needs GPs to feel interested and involved in supporting ladies who are pregnant
5. Consultants and families sharing decisions about birth and feeling able to have positive and sometimes challenging conversations about the risks and birth options is a good thing
6. A good personalised approach to care planning includes a flexible birth plan that covers antenatal, and postnatal care and recognises that unexpected things are very likely to happen to most families at some point in their journey so that families are open to discussions about different options when things change
7. Because of the rural nature of this community, having local routine care and local contingencies in place to deal with maternity emergencies safely across Shropshire, Telford and Wrekin is critical to great maternity service
8. Really responsive triage that provides quick, effective, personalised reassurance when unexpected things happen and that supports women to judge their progress in labour as accurately as possible so they get to their chosen birth place in time are vital design features of our maternity triage service – especially in rural localities

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9. Having flexible antenatal appointments close to home, with time for discussion, good explanations and the chance to meet mums with a similar birth dates is key to a good antenatal experience
10. Good, safe birth experiences in Shropshire Telford and Wrekin need to be preserved
11. Good postnatal care really matters. Even though most of the benefits are realised in other parts of the NHS system, because it helps build the foundation for happy, healthy families from the start, investment in great postnatal care that delivers the following benefits is really important for community resilience:
    - Really good support with breast feeding
    - Having a safe space and support to reflect on and process the birth experience – especially when it has been traumatic for the mind and body e.g. an emergency caesarean or other difficult birth issues
    - Supporting bonding and connection with mum and the rest of the immediate family (partner and other children)
    - Transitioning to parenthood with confidence
    - Meeting and connecting with other women who often become life-long friends and a source of ongoing support

    Design needs to recognise that good postnatal care is even more important after a highly medicalised or traumatic birth – especially one that involves surgical intervention or physical injury.

12. The design of all routine antenatal and postnatal maternity care and environments, including wards, should support mums to interact, meet and make friends with others with children of the same or similar birth date.
13. How midwives and the maternity workforce feels really matters. The design of the maternity system needs to let midwives feel in control again, and involve staff in decisions, the planning and improvement of maternity care in Shropshire, Telford and Wrekin.
14. We very quickly need to design services and different ways of working that restore maternity staff resilience in Shropshire, Telford and Wrekin.
15. Maternity money flows, tariffs and outcome measures should all align better with what matters and support the creation of healthy, happy families alongside delivering babies so that other parts of the maternity journey are valued too. We need to measure different things within our maternity service in different ways, and in particular measure the things that staff and families have told us matter to them in these insights.

## 7. Key Findings and Considerations : Phase 2

7.1. The findings from Phase 2 have provided some evidence towards supporting a position in relation to each of the elements this review was set to consider. A summary of Phase 2 findings is provided below:

7.1.1. Is the clinical model of delivery currently in place in Shropshire, Telford and Wrekin clinically sustainable? Is the staffing of the units appropriate for the requirements and is there a clear workforce plan to support service delivery?

*The findings from Phase 1, that the current workforce is fragile and staffing levels and skill mix need to improve in order to enable a stable workforce are supported by the findings from Phase 2.*

*Staff report that morale is low. Whilst in general relationships within teams are good, relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported*

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*by management. This is more pronounced amongst staff based in MLUs and the community than those who work solely in the consultant led unit. Staff report that antenatal and postnatal care are now very time pressured, and whilst in the past they delivered great family centred care, they feel this is changing as a result of changes made to the service. Birth is still a high point for most; although the unpredictable nature of birth; unrealistic expectations and a sense of being under-resourced get in the way.*

*Families living in both rural and urban communities told us they experience continuity and that they value it highly. Families really value the support women's care assistants provide to them postnatally, particularly with breast feeding and caring for baby in the early days.*

*Women's support assistants and midwives report that recent changes are compromising the care they are able to offer as there is not enough time during appointments and home visits. Staff are worried that 'something will be missed' as they don't have enough time with women.*

*Increasingly, midwives do not feel in control of their working lives. They feel frustrated and angry. Staff feel disengaged from and let down by senior managers. Midwives report that not feeling in control is impacting on their work and home lives and on their emotional wellbeing, health and happiness. Staff feel they are letting their ladies down – especially in areas where there have been MLU closures.*

*Relationships between staff in the MLU and consultant led unit (CLU) were described as "them and us" by staff. This is exacerbated by the perception that the CLU "takes" MLU staff, but there is no reciprocity when MLU is busy. Families report mixed experiences of relationships with consultants and consultants recognised that building relationships with families could be difficult as generally they only got involved when things were not going to plan. MLU midwives in particular reported difficult relationships with the triage service. They described it as a battle to get women seen. Members of the triage team researchers spoke to did not mention these issues.*

7.1.2. Is the safety of, and are the clinical outcomes from, the current model acceptable for Shropshire, Telford and Wrekin patients? Are there any quality concerns relating to the service?

*Whilst women did not report any issues relating to quality and safety, some concerns were raised by midwives.*[11]

*Midwives reported that changes in working practices were compromising continuity and their close relationships with women. Midwives perceive that it is becoming more difficult to support women well during the antenatal period due to changes in the way care is being provided. Midwives reported that as a result of changes in the care model being implemented, their experience of being able to identify when a woman is struggling was changing. Some said they now had less time and a short visit was not enough to spot that women were struggling. They were concerned that problems would be missed.*

*Midwives also say the way call outs and on call arrangements are managed is getting in the way of great - and even safe - maternity care. Staff talk about "being pulled out" of their day job to work in the consultant led unit, and how disruptive that is. Working in different and unfamiliar environments is difficult and some staff feel it is risky.*

[11] The CCGs subsequently took action to look further into the concerns raised and take any action as required to ensure that services are safe and any issues regarding relationships between management and frontline staff are addressed.

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*The findings from Phase 2 support the findings from Phase 1 that consideration needs to be given to how midwifery services can work with other wider services to further improve longer term outcomes for women and their families.*

7.1.3. Are there any concerns relating to rural access to the services?

*Families and staff told us that in Shropshire, Telford and Wrekin, transport is a really important factor in their decisions and choices around birth and maternity care. People worried most about travelling to their place of birth when they were in labour and about birth before arrival. Because those who had to travel to the consultant led unit were usually also the ladies at highest risk, both staff and families worried that if more people were travelling and there was no or limited access to midwife services locally in case of emergencies, birth outcomes would get worse.*

7.1.4. Are the MLUs financially sustainable?

*Information relating to the cost/financial sustainability of MLUs was not gathered through Phase 2.*

7.1.5. Does the current model provide value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability?

*Phase 2 did not consider information relating to cost. However, findings in relation to rural access, clinical outcomes, safety and clinical sustainability can be used to inform the overall position with regards an assessment of overall value for money.*

# Phase 3 : Co-design workshops

## 8. Co-design workshops

8.1. Phase 3 included a series of co-design workshops at which women and their families, professionals and others with an interest in midwife led units came together to discuss what the future model of midwife led services may look like.

8.2. This section of the report summarises the findings of Phase 3 and sets out the feedback from the community about the way forward for midwife led maternity services. The ideas described in this section were generated at 9 co-design workshops held across the county in September 2017. The table below summarises the locations and attendance for each co-design workshop.

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| Co design workshops | |
|---|---|
| **Venue** | **Attendance** |
| Shrewsbury (day time) | 26 |
| Oswestry Workshop | 30 |
| Ludlow Workshop | 28 |
| Bridgnorth workshop | 22 |
| Shrewsbury (evening) | 6 |
| Telford | 12 |
| Market Drayton | 7 |
| Additional session Shrewsbury (evening) | 1 |

8.3. In total 127 people attended the workshops, as 5 people listed in the workshop attendance attended two workshops.

8.4. The shared ambition developed through the co-design workshops responded to and built on the findings from Phase 1 as well as the insights generated from Phase 2. The key elements of the shared ambition developed through the co-design workshops (Phase 3) are described below.

8.5. The importance of healing history[12]: Participants recognised that there has been a difficult shared history over the last few months, with significant loss of trust in the "system" and a perception amongst community leaders that decisions had already been made. This has been fuelled recently by messages about a new care model issued by Shrewsbury and Telford Hospitals Trust (SaTH), which has continued to muddy the water. These messages were not aligned with commissioners' intentions, expectations nor with the timeline for the commissioners' decision making process.

8.6. Shropshire, Telford and Wrekin commissioners have been absolutely clear in the public domain that no decisions have been made about the care model, and that the community will be involved in the decision-making process moving forward.

8.7. The community fed back at workshops that the Midwife Led Unit (MLU) Review could not be seen in isolation from other ongoing reviews e.g. Future Fit; The Ovington Review; The Secretary of State Review. Decisions within those reviews would impact on the community's perception and expectations of the MLU Review.

8.8. There was a recognition that the MLU Review needed to be linked to other reviews and activity taking place e.g. initiatives around neighbourhood working.

8.9. There was a need to regain trust and start being respectful towards each other. All stakeholders agreed that it was time to heal recent history and move forward positively and together for the sake of the future maternity service and so that this shared ambition can be fully realised.

8.10. Overarching Principles : The community identified 7 overarching principles for the service model that were especially important. They were:

- Safe births
- Equality and sustainability across the county
- Everyone being treated with respect and as an equal

[12] "Attending to history" is recognised by health service researchers as a critical success factor for larger scale transformation and change management https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3479379/



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- Family and community centred care
- A more social and less medical model of care
- Partnership working
- Maternity staff being fully involved in care model development

8.11. Specific elements of the care model : There was great synergy across all workshops, which suggests that the elements described here are the main ones to focus on. They also closely align with the insights generated from Phase 2.

8.12. The community wants both families and maternity staff to have a positive experience and be safe throughout their respective journeys. They described key elements of the care model that the community values most, and that any future midwife led service design needs to incorporate. They said we want:

8.12.1. Midwife led care to support families to thrive

*The community wants to start with the end (outcome) in mind and work backwards from there. The current maternity service focuses mainly on birth. The community wants the system focus to be family life. By broadening the system focus, antenatal and postnatal care and support transition to healthy family life becomes valued as well.*

8.12.2. Midwife led care is relationship-centred and builds community

*The community wants service design and delivery that supports strong relationships and connections between midwives and women and their families and between parent peers (strong mum friendships circles). This means a maternity service that supports continuity of care, with one midwife or small teams of local midwives working together to support women and families they know through their journey from antenatal to postnatal.*

*A relationship centred care model means having contact with all women within their communities, and creating time to talk and discuss what matters to parents – especially when unexpected things happen. It means routine antenatal and postnatal care being delivered differently and potentially in group clinic settings instead of mainly one to one.*

8.12.3. Midwife led care responds to a 'family centred plan'

*The community recognised that the term "birth plan" reinforced the system's narrow focus on birth. Because they wanted the service to take a broader focus and value antenatal and postnatal care too, the name of the plan needed to change to signal a fundamental change in emphasis. Home birth was a choice that should be available as well. The plan needed to encompass the whole journey towards becoming a family and recovering beyond birth – including a plan for postnatal care and one that supported transition into early years' services (health visiting and children's centres support).*

*Managing expectations, sharing decisions, knowing their choices and making informed ones was also an important element of the family plan. Whether women were high or low risk, feeling involved in decisions was very important to them. The whole family needed to be involved and recognised in the*

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*family plan, including partners.  Mapping and recognising the level of family support an expectant mum had was also critical to a personalised family centred plan – especially when a woman had no family to support her.   Avoiding stereotyping mothers who have had previous pregnancies and have other children was also important. Every birth is unique and different.*

*The community felt also that currently expectant parents had to make their choice about place of birth too early, and this decision should be deferred to 36 weeks. This was proposed as a bold step. Staff also needed to be equipped and have tools to support and promote choice and to identify and support vulnerable families so they got the right support.*

8.12.4. Midwife led care responds proactively and equally to physical and mental health issues

*Maternal health is critical to families thriving. The community said that access to support when a parent was experiencing mental health issues needed to improve. They wanted parity for mental health issues, and for parents to have access to help when they needed it so they keep well in both mind and body.*

8.12.5. Midwife led care is provided in the heart of the community

*The community recognised that there are many existing services that support family life, and they could be joined up and centralised.  The community talked about the potential for midwife led services to be delivered from community places that had a broader social rather than a medical purpose.   These centres would build on the places and things communities already have, and be different in different communities, responding to the particular needs of that community e.g. in market towns in South Shropshire, transport access can be difficult which would affect location of the centre. In other areas, the centre might be in the middle of town or in children's centres, maternity clinics or village halls. In other areas, the centre might be located in a place that is easier to access through existing transport links.*

*In this way, family support services, including maternity services, would become highly personalised to communities and not just to families.  These places would also be strongly community led – potentially social enterprises with local parents involved in setting them up and running them. There would be Wifi, refreshments and play areas so that families could drop in; build social networks and connections. They would help eliminate social isolation. Breastfeeding support, childcare and parenting groups could be based here.*

*These places would be opening and welcoming and designed to be accessible - not only from a transport point of view; also culturally e.g. parents under 25 as well as parents over 25; those with complex health or social circumstances or who have a disabled child, and those who work would all feel included, and supported to network with peers who share their experiences and understand their personal challenges. There needed to be out of hours support for working women and their partners.*

*These places would also be an environment that supports staff development. They would link and connect multidisciplinary teams of professionals, providing planned care and support to families from these centres. Consultants could consult in these centres. They would provide a focus for GPs to stay connected.*

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*There are already places in many communities that could offer a home for this kind of midwife led care, and mapping those community resources would be an important next step. Working from the same place would build more empathy and positive relationships between professionals and also join up referrals and care planning.*

*These centres would in effect become the central focus within communities for those expecting a baby or raising a child. Amongst many other things, they would offer:*

- *Information and advice*
- *Access to routine care and support and reviews before and after birth and into early years*
- *Signposting e.g. breastfeeding support; voluntary sector*
- *Mothers' groups and community building across antenatal and postnatal care.*
- *They could also harness positive community building through social media – facebook/ twitter and what'sapp to keep local mums connected in the virtual world.*

*A recurrent theme across several of the workshops was the idea of remote communities having access to a 'mobile pregnancy and early years services' that mirrored this model and came to where women live.*

*There was support for this community-based model across all workshops. The role of MLUs within the context of that model was not discussed in detail. However, views in relation to the role of MLUs in the future model varied. Community workshop participants called both for MLUs to be open 24/7; be staffed with higher band staff and offer antenatal and inpatient postnatal care and to be closed because there are too few births in MLUs.*

*Several workshops also recognized and proposed that postnatal care could be home based, and antenatal care could also be provided in settings other than an MLU.*

*Some members of the community believed all women wanted MLU births – or that they would want them if there was more balanced media coverage about MLUs and women knew that MLU deliveries were safe and available. This was challenged by experienced maternity staff at workshops who reported that women – even women who fell into the low risk birth category – were voting with their feet and choosing birth in the consultant led unit. This made it challenging to increase birth rates at MLUs.*

*The community recognised that negative press coverage fuelled this shift, and more could be done to promote MLUs as a very safe place to give birth. The community felt that the local press, maternity staff, commissioners, SATH, and local campaigners all owned the challenge of changing perceptions about MLU birth.*

*A bold step to reverse the current trend that came from this same workshop was that women should not have a choice and if their risk was low, the default should be an MLU birth.*

8.12.6. Support early in pregnancy

*Caregivers need to acknowledge women's birth histories, which may include traumatic experiences and memories that impact across subsequent pregnancies. Acknowledging women's feelings and the need to heal is important – especially in early pregnancy. Some people felt that vulnerable women*

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*may need support earlier in pregnancy, and one workshop felt that women needed better information early in pregnancy.*

8.12.7. Great perinatal mental health support

*Reflecting the principle that emotional and physical wellbeing are equally important, people wanted improved and more proactive support for women experiencing mental health issues during pregnancy and into early years and training in perinatal mental health for staff across maternity and early years.*

8.12.8. Review risk classifications and management of high risk women

*An issue that emerged at several workshops and in the insights generated by Phase 2 was that the current risk stratification process gets in the way of more women being eligible for MLU births. The community wanted to see a review of the current risk classification framework, and also strongly supported an idea floated at several workshops (a bold step) that assessment of a woman's risk should happen later in pregnancy - around 36 weeks - rather than channelling women into the 'high risk' category in the first trimester as currently occurs. The community believed that closer connectivity between providers like public health and GPs could also help make risk assessments more accurate – and even help reduce risk e.g. weight loss and smoking cessation services. The community also suggested that expert peers and midwives as well as specialists could and should support discussions about risk and choice.*

8.12.9. A safe, familiar place to give birth

*The community saw safe births as an extremely important element of the midwife led care model. It was in the top three most important elements of care and support, as voted for by participants in this co-design process. Because it is a rural county, giving birth in a safe place needed to take account of travelling times. One workshop suggested there needed to be a 'maximum travel time to get to place of birth' as a service quality criteria.*

*The community also asked that the consultant led unit be moved to a more central location within the county. Technology was recognised as an important enabler of connectivity and care; potentially supporting safe triage. One workshop also suggested birth centres offering virtual tours to support women's decision making process and choice. However, participants felt technology could not replace human contact.*

8.12.10. Great postnatal care for everyone

*The community wants excellent postnatal care for everyone, with urban and rural areas on a par. The community recognised that some women need inpatient postnatal care, and this should be great when it is delivered. Postnatal care involves both maternity teams and health visitors. The community recognised the impact of 60% cuts in health visitor budget and one workshop called for more health visitors. Current system design means that boundaries are rigid and staff feel pressure to discharge and transfer care at 10 days. Current boundaries may be artificial and service rather than family and relationship centred.*

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*Several workshops recognised that postnatal care could be home based, and both post- and antenatal care could be provided in settings other than an MLU. Breastfeeding support was important. For new mums to gain confidence and succeed, it needed to be available over time and beyond initiation.*

*Two workshops proposed 'on call 24/7 advice with a real person at the end of the phone to offer support'. Consistency of advice was important. Two workshops suggested that education about breast feeding needed to start during antenatal care.*

*There was very strong message that health visitors and midwives should work much more closely together to deliver postnatal care and support.*

8.12.11. Well supported, trained staff; new workforce models

*The community wants their frontline maternity staff to have a bigger say and be more involved in the improvement of midwife led care. They want staff to be well trained and supported, and to work in environments that support personal and professional development. Their managers need access to leadership training.*

*They want maternity staff to have the right skill mix to support women safely and appropriately, and for midwives to have more flexibility, power and autonomy for delivering outcomes. Lone workers need to be supported well when doing call outs.*

*Training and information systems need to ensure one clear message to families. There needs to be a plan in place to address recruitment and retention in midwifery. One workshop called for expansion of employment opportunities and for nurses to train to expand the midwifery workforce. One workshop called for more staff. There was also a call for professional boundaries to be explored to bring in skills held by other people and organisations.*

*In terms of workforce development, the community suggested new roles with maternity care:*

- *Trained peer supporters / buddies*
- *Consultant midwives*
- *GPs with a special interest in maternity care*
- *Lactation consultants*
- *Midwife support workers*
- *Extended roles for womens' support assistants (WSAs)*

*The community also embraced opportunities for a broader range of providers. Some participants also wanted GPs to be more involved.*

8.12.12. Improved communication and joint working

*Improving communication and more effective working relationships across the service was a recurrent theme. The community believed that improving personal relationships; having up to date and integrated IT systems and integrating planning would lead to closer collaboration and more joined up working. Being co-located in the same community place could help too.*

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*One workshop suggested there should be closer collaboration and greater connectivity with services that work to reduce risks in pregnancy to lower the risk profile of women more proactively e.g. weight management services; smoking cessation.*

8.12.13. A model built on evidence and best practice

*The community said that the midwife led care model needed to build on research evidence, local knowledge, best practice and NICE guidance about what works and delivers good outcomes. The community supports Better Births policy. Learning from the maternity vanguard pilots as well as other national archives of best practice needed to inform the way forward.*

*The community also wanted to learn from local best practice and it wanted to involve staff in service improvement and design.*

8.12.14. New outcomes and measures of impact

There was strong support for measuring value in a different, more family outcomes focused way. There was also recognition that the same or very similar outcomes matter from -9 months to early years, and that shared outcomes could support joined up budgets, commissioning and integrated provider working.

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| MLU Review Proposed Changes Summary Table | | |
|---|---|---|
| **Current Provision** | **Proposed Provision** | **Rationale** |
| **Pre-Pregnancy** | | |
| All women have access to universal public health services relating to healthy lifestyles. Women with a specialist need have access to mental health services provided by South Staffordshire and Shropshire NHS Foundation Trust (SSSFT). | It is proposed that, through the Local Maternity System, Public Health and Mental Health services are enhanced in order to provide multi-disciplinary information and support with regards to getting pregnant and being healthy during pregnancy. This should include information, advice and support from professionals in relation to:<br><br>- Contraception and Sexual Health<br>- Conception<br>- Mental Health<br>- Healthy Lifestyles<br>- Long Term Conditions<br><br>In addition, it is proposed that the services pre-pregnancy also offer comprehensive information on-line as well as facilitating peer support networks. New pathways, joint training and information sharing to enable professionals in different services to work well together, including improved information sharing, rotation of training across professionals and multi-agency information available on-line for professionals.<br><br>Note : These services sit outside of the scope of the MLU review, but are included here for completeness. This proposal will be put forward to the LMS for action. | Health of women in pregnancy will be improved. This will facilitate a greater number of low risk, midwife led births as well as improving longer term health outcomes for women and their families. |

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| Pregnancy | | |
|---|---|---|
| Access to services is unclear and disjointed, with some women accessing services via their GP and some contacting maternity services directly.<br><br>Women receive antenatal care from community midwives, who operate from 5 MLUs (1 x Alongside (AMU), 4 x Freestanding (FMU)) and 2 community bases.<br><br>Ultrasound scanning is available in MLUs in most parts of the county.<br><br>Day Assessment is available in MLUs in some parts of the county.<br><br>Obstetric clinics are available in MLUs in some parts of the county.<br><br>Women with an identified mental health need receive support through a specialist service provided by SSSFT. | It is proposed that access to maternity care is improved through self-referral via a single phone number to register directly with maternity services. In addition, improved electronic and online information should be developed, which includes a broad range of local information and advice for pregnant women and their families.<br><br>Bases across the county should be developed that are available for at least 12 hours a day for midwifery led care. A range of different services should also be available at the bases. It is proposed that these bases replace the current model of MLUs for midwifery led care (note in the Birth section that it is proposed that 1 x AMU and minimum 1 X FMU are retained – these may also act as bases for those areas).<br><br>The same services should be available in each of the bases at times which suit women accessing the services. The location of the bases will be defined by likely population demand and will be easily accessible by car and public transport. Services available will include;<br><br>- Antenatal care from a midwife<br>- Support from Women's services assistants<br>- Planned antenatal appointments with an obstetrician<br>- Scanning and fetal monitoring for all | The bases will ensure that women have equal access to services across the county. Women will have improved access to a range of services related to pregnancy – they can access them from the same place and can build relationships with peers accessing the services in order to support each other.<br><br>The sustainability of the service will be improved through more integrated working and improved skill mix within the midwifery led care service. In addition, service availability will be shaped around local demand and activity. The staffing model will require fewer midwives to 'staff' bases, enabling more midwives to be able to flexibly respond to demand.<br><br>Services will be close to home for women and more joined up. Local services will be available at times that suit the women who use them. |

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| | trimesters (not including labour)<br>- Antenatal day assessment, including CTG monitoring<br>- Support with emotional wellbeing and mental health (action for LMS)<br>- Support with long term conditions during pregnancy<br>- Healthy lifestyle services, including smoking cessation and weight management services (action for LMS)<br>- Information and advice about pregnancy and parenthood including antenatal classes/groups, breastfeeding, baby care and life skills such as budgeting and cooking (some provided by SaTH, some for action by LMS)<br>- Information and advice about birth options<br>- Peer Support (action for LMS)<br><br>A team of community midwives who have a caseload that is in line with national guidance will support women with planned antenatal care. They will have strong links with local GPs and will be supported by maternity support workers who are able to assist with tasks such as routine phlebotomy, urine testing and weight measurements.<br>Women will have access to midwife advice and support 24/7. This will include advice and support in person, through video call or over the phone. | |

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| | Women and the professionals working with them will have access to up to date information electronically (action for LMS).<br>Peer support networks are in place, where women and their partners are able to link in with others if they want to, to share experiences through initiatives such as drop in 'cafes' and online networks (action for LMS). | |
| **Birth** | | |
| Women have a full choice of birth options, delivered through:<br>1 x consultant led unit<br>1 x AMU<br>4 x FMU<br>Home Birth | Women have a full choice of birth options and will be able to give birth at the consultant led unit at Princess Royal Hospital (PRH), at the Alongside MLU at PRH, a Freestanding MLU in Shrewsbury and at home.<br><br>A community team will be available 24/7 for midwife led births in the midwife led units and at home.<br><br>There will be improved pathways with maternity services over the border (particularly Wrexham, Hereford and Worcester) to facilitate easier access to services in those areas for women choosing to do so. | Clinical and Financial sustainability will be improved through more effective use of skill mix within teams. Whilst maintaining a full choice of birth options within county, reducing the number of MLUs will enable staffing to be deployed more effectively in line with demand.<br><br>The current AMU, whilst technically an AMU as it is on the same site as the consultant unit, is not within close enough proximity to the consultant led unit for a greater level of risk to be safely managed in the AMU. Consideration needs to be given to re-locating the AMU closer to the consultant led unit in order to seek to facilitate an increase in midwife led births. SaTH are currently exploring this, as there are other services currently within the women and children's centre at PRH which could potentially be moved to elsewhere in the hospital, enabling the AMU to be |

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| | | closer to the consultant unit.<br><br>The proposed model is designed to increase the number of midwife led births by: Over time, improving the health of women during pregnancy; Changing pathways in antenatal care so that all women receive care that plans for a midwife led birth, unless this won't be safe for the woman or her baby, or she chooses consultant led care for another reason; Enabling women to make a decision about their preferred place of birth later in pregnancy; moving the alongside midwifery led unit closer to the consultant led unit in order for a different level of risk to be safely managed. |
| **Postnatal** | | |
| Women have access to inpatient postnatal care in MLUs and as outpatients at home. | A team of community midwives and women's support assistants will be available 24/7 to offer advice and support after the woman has given birth (this will be available from as soon as the mother returns home, or as soon as the midwife who delivered the baby at home has left). This support and advice will be available either in person, through a video call, or over the phone.<br><br>Bases across the county will be available for at least 12 hours a day for planned midwifery led care. A range of other different services will also be available at the bases. The same services will be | Excellent postnatal care will be available consistently across the county. Clinical and Financial sustainability will be improved through more effective use of skill mix within teams and with staffing configuration better matching service demand. |

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| | available in each of the bases at times which suit women accessing the services. Services available will include;<br>- Postnatal care from a midwife<br>- Support from Women's services assistants<br>- Newborn checks and screening<br>- Drop-in service or planned access during a 12 hour period to enable support, for example with feeding, confidence building, baby care skills<br>- A space for women and their families to reflect on the birth experience<br>- Support with emotional wellbeing and mental health<br><br>- Support with confidence building and bonding<br>- Support with feeding<br>- Support with long term conditions postnatally<br>- Healthy lifestyle services<br>- Information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking<br>- Peer Support | |

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## 9. Key Documents/Information Sources

The table below lists the key documents/information sources used to inform this review to date.

| **Key Documents/Information Considered for Phase 1 MLU Review Report** | |
|---|---|
| **Document** | **Web Link (if available)** |
| Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE) | https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf |
| Implementing Better Births: A resource pack for Local Maternity Systems (March 2017, NHSE) | https://www.england.nhs.uk/wp-content/uploads/2017/03/nhs-guidance-maternity-services-v1-print.pdf |
| Saving Babies' Lives: A care bundle for reducing stillbirths (March 2016, NHSE) | https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf |
| Saving Lives, improving mothers' care (Dec 2016 MBRRACE UK) | https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202016%20-%20website.pdf |
| CQC's response to the 2015 survey of women's experiences of maternity care | http://www.cqc.org.uk/sites/default/files/20160125_maternity_survey_2015_cqc_response.pdf |
| NHS Hospital Episodes Data 2015-16. Summary Report | http://www.content.digital.nhs.uk/catalogue/PUB22384 |
| National Maternity and Perinatal Audit 2017 | http://www.maternityaudit.org.uk/pages/home |
| NICE Guidance, Pathways and Standards | https://www.nice.org.uk |
| Costing statement: Intrapartum care: care of healthy women and their babies during childbirth<br><br>Implementing the NICE guideline on intrapartum care(CG190) (NICE 2014) | https://www.nice.org.uk/guidance/cg190/resources/costing-statement-pdf-248729581 |
| The state of maternity services in England<br>Policy briefing<br><br>(Picker Institute, July 2016) | http://www.picker.org/wp-content/uploads/2016/07/Maternity-services-policy-briefing-V2.pdf |
| The state of maternity services (Royal College of Midwives 2016) | https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf |
| Safe midwifery staffing for maternity settings (NICE Feb 2015) | https://www.nice.org.uk/guidance/ng4 |
| Support Overdue: Women's experiences of maternity services (WI and NCT 2017) | https://www.thewi.org.uk/__data/assets/pdf_file/0009/187965/NCT-nct-WI-report-72dpi.pdf |
| National Tariff Information | https://improvement.nhs.uk/resources/national-tariff-1719/ |
| Compendium of Maternity Statistics, England (HSCIC April 2015) | http://content.digital.nhs.uk/catalogue/PUB17333 |
| Births in England and Wales, Summary Statistics (ONS) | https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummar |

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| | ytablesenglandandwales/previousReleases |
| Maternity Services Statistics (NHS Digital) | http://content.digital.nhs.uk/maternityandchildren/maternitymonthly |
| Maternity Services Reports (NHS Digital) | http://content.digital.nhs.uk/maternityandchildren/maternityreports<br><br>http://www.content.digital.nhs.uk/catalogue/PUB22384 |
| Information received from CCGs and Providers about maternity services in their area | N/A |
| Information received during service visits to other areas. | N/A |
| Information from the service provider (SaTH) | N/A |
| Information held by Shropshire CCG and Telford & Wrekin CCG | N/A |
| Public Health and JSNA Information (not all available on-line) | https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/1/gid/1938132997/pat/6/par/E12000005/ati/102/are/E06000051<br><br>http://www.telford.gov.uk/info/20121/facts_and_figures/924/population_profile<br><br>https://www.shropshire.gov.uk/joint-strategic-needs-assessment/ |
| Feedback about maternity services held by Healthwatch Shropshire and Healthwatch Telford & Wrekin | N/A |
| Feedback about maternity services gathered by local campaign groups | N/A |
| Feedback about maternity services gathered by SaTH | N/A |
| CQC Quality Report – Royal Shrewsbury Hospital | http://www.cqc.org.uk/location/RXWAS |
| Maternity Services Monthly Statistics | http://www.content.digital.nhs.uk/catalogue/PUB24142 |
| Safe, sustainable and productive staffing<br>An improvement resource for maternity services<br>June 2017 (National Quality Board) | https://improvement.nhs.uk/resources/safe-sustainable-productive-staffing-maternity-services/ |
| *Note : Shropshire, Telford and Wrekin CCGs are committed to ensuring this review is as open and transparent as possible. Therefore the CCGs will seek to ensure that, where possible and appropriate, any information not currently publicly available, is made publicly available through the CCG websites.* | |

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Shropshire Council

Date: Thursday, 22 March 2018

Time: 2.00 pm

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Contact: Amanda Holyoak, Scrutiny Committee Officer
Tel: 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

# JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

# TO FOLLOW REPORT (S)

## 4 Shropshire, Telford and Wrekin Midwife Led Unit Service Review (Pages 1 - 58)

To receive and consider information on the Shropshire and Telford and Wrekin Midwife Led Unit Service Review, and particularly

The Current Position
Impact Assessment
Proposed Service Model
Consultation document and Consultation Plan

The following will be present at the meeting:

Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin Local Maternity System
Adam Gornall, Clinical Director – Women & Children, Shrewsbury & Telford NHS Hospital Trust (SaTH)
Dr Jessika Sokolov – Clinical Lead, Shropshire Clinical Commissioning Group
Sarah Jamieson – Head of Midwifery – SaTH

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**Agenda item:** GB-2018-03.065
**Shropshire CCG Governing Body meeting: 14 March 2018**

| | |
|---|---|
| Title of the report: | Shropshire, Telford and Wrekin Local Maternity System (LMS) Transformation Plan |
| Responsible Director: | Christine Morris, Executive Nurse, Telford & Wrekin CCG and Senior Responsible Officer LMS |
| Author of the report: | Christine Morris, Executive Nurse, Telford & Wrekin CCG |
| Presenter: | Dr Jessica Sokolov, Deputy Clinical Chair, Shropshire CCG |

**Purpose of the report:**

To present to the Governing Body the Shropshire, Telford and Wrekin Local Maternity System (LMS) Transformation Plan.

**Key issues or points to note:**

Better Births was published in February 2016. This document sets out a vision for the transformation of maternity services to promote safer and more person centred care delivery.

In order to implement the recommendations within Better Births NHS England (NHSE) have instigated a National Maternity Transformation Programme and are monitoring delivery at STP level through the Local Maternity Systems (LMS).

The LMS across Shropshire have worked collectively to develop a transformation plan for delivery over the next 3-5 years in accordance with NHSE timelines. The plan implementation will be a dynamic and evolving process that is co-produced with women and their families to ensure services commissioned and delivered are equitable, the safest they can be and delivered within the financial envelope we have as commissioners.

The LMS plan was submitted as a draft in October 2017 with positive feedback received. A second version to respond to the key lines of enquiry has been submitted on 12th February 2018. This version is now in on the CCG website with links to LMS partner's websites.

**Actions required by Governing Body Members:**

To note the content of the Shropshire, Telford and Wrekin Local Maternity System (LMS) Transformation Plan and support its implementation system wide.

| **Does this report and its recommendations have implications and impact with regard to the following:** | | |
|---|---|---|
| 1 | Additional staffing or financial resource implications<br>There is a nationally set tariff for maternity care however it is known that in all areas this does not fully cover all maternity costs, as a result a commitment has been given by NHSE to review the maternity tariff. The plan developed builds on the existing services and financial modelling is the next step of the process recognising that the system cannot afford additional cost pressures.<br><br>A bidding process for non-recurrent monies is in place to support the transformation agenda. | No |
| 2 | Health inequalities<br>*If yes, please provide details of the effect upon these requirements* | No |
| 3 | Human Rights, equality and diversity requirements<br>Impact assessments will be undertaken to promote inclusions | Yes |
| 4 | Clinical engagement<br>The LMS Programme Board includes midwives, obstetricians and clinicians from other associated health maternity services. | Yes |
| 5 | Patient and public engagement<br>The plan has been devised following consultation with women and their families and stakeholders and will be progressed through an ethos of co-production. The Maternity Voices Partnership is in place with a post out to advert for a coordinator to support this. Healthwatches Shropshire and Telford & Wrekin are actively engaged in this work.<br><br>This work demonstrates an opportunity to improve maternity services in line with Better Births recommendations. There is a risk that service changes will be challenged if the system does not engage appropriately with the population on service changes. | Yes |
| 6 | Risk to financial and clinical sustainability<br>*If yes, please provide details of the effect upon these requirements* | Yes |

**SHROPSHIRE CLINICAL COMMISSIONING GROUP - GOVERNING BODY**
**14 March 2018**

# Shropshire, Telford & Wrekin Local Maternity System (LMS) Transformation Plan

## Introduction

1.1 This report shares with the Board members the work of the Local Maternity System (LMS) in delivering the five year transformation of maternity services in accordance with the national NHS England agenda.

## Background

2.1 Following the publication of the national review of maternity services (Better Births 2016); a transformation plan for maternity services in Shropshire, Telford and Wrekin has been developed through the Shropshire, Telford and Wrekin Local Maternity System. This plan sets out how transformation will be achieved in line with the requirements of Better Births which are to;

**Improve choice and personalisation of maternity services so that:**

- All pregnant women have a personalised care plan;
- All women are able to make choices about their maternity care, during pregnancy, birth and after their baby is born;
- Most women receive continuity of the person caring for them during pregnancy, birth and after their baby is born;
- More women are able to give birth in midwifery settings (at home and in midwifery units)

**Improve the safety of maternity care so that all services:**

- Have reduced rates of still birth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030[1] as outlined in NHS England's 'Saving Babies Lives, A Care Bundle for reducing stillbirth'.
- Are investigating and learning from incidents and sharing this learning through their LMS and with others;
- Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement Programme.

## Implementation

3.1 A local multi-agency board is in place to oversee and drive the required transformation supported by the Sustainability Transformation Partnership. This will be an evolving process over five years and not a

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

static process. The first version of the plan was submitted on 31st October 2017 with positive feedback given to the system. A second version was required to be submitted 12th February 2018 to include feedback on additional lines of enquiry. (The version in appendix 1 is dated February 2018). Oversight and monitoring of the plan is undertaken via the NHS England Regional Maternity Board reporting into the National Maternity Transformation Board.

3.2 The Local LMS work is supported by Programme Manager – Fiona Ellis and Programme Support Officer- Helen White, working with leads from all partners across the work streams stated within the plan.

3.3 In addition to the plan delivery work there are supportive measures in place nationally to share best practice and bid for non- recurrent transformational funding.

3.4 The ethos of the local plan is that it is driven in co-production with those who are using our services and the work of the Maternity Voices Partnership will be key in ensuring we deliver the transformation that meets to needs of local women and their families.

**Recommendations**

4.1 The Board is asked to note the content within this report.

**Christine Morris**
**Executive Nurse and SRO LMS**

21 February 2018

# TRANSFORMATION PLAN

# IMPROVING OUTCOMES OF MATERNITY SERVICES IN SHROPSHIRE AND TELFORD & WREKIN

**A FUTURE VISION AGREED IN PARTNERSHIP**

**2017 - 2021**

## Foreword

Across Shropshire, Telford and Wrekin each year around 5,000 babies are born. In planning and delivering maternity services, we often focus on the birth of a child and don't always think about the lifelong journey each child and their parents and carers will have. This plan aims to change that. The birth of a child is a very significant event and what happens before, during and after that event has a long-term impact on the emotional and physical wellbeing of the child, their parents and carers. In delivering the vision outlined in *Better Births*, together we will ensure we understand what we need to do so that services for pregnant women, babies and their families have a positive impact on children, their parents and carers in the longer term.

Our priority in transforming maternity services is ensuring the safety of women and their babies at all times. As an Local Maternity Services( LMS), we are aware that maternity services in Shropshire, Telford and Wrekin over the last few years have been under scrutiny in relation to safety and the care of women and their babies. We recognise this is very difficult for women and their families who are currently using the services in Shropshire or who have done so in the past. We have been considerate of the safety improvements that have been made to date and this plan and all its partners will ensure that learning from all external reviews is fully embedded as we move forward to enable the highest possible level of safety to be achieved for all.

This is the start of a new chapter for maternity services in Shropshire, Telford and Wrekin. Through the work of this plan a range of professionals will work together with women and their families to re-build trust and to provide assurance in relation to the quality and safety of services. We will ensure we listen to and learn from each other, constantly improving services and experiences and developing a learning culture.

Through implementing this plan we will strengthen how we work together in planning, delivering and improving services for pregnant women, babies and their families. Services will be safer. Women across Shropshire, Telford and Wrekin will have easy access to a range of good quality services for them and their babies regardless of where they live. Women will continue to have a choice in the care they receive and will be more likely to know the midwife that will care for them throughout pregnancy, birth and after their baby is born. The way we offer services will be different – the services women and their babies receive will be more personalised and designed around their individual needs and preferences.

We are delighted that right from the beginning of this journey of transformation, women and their families have come forward to work together with other maternity system partners to transform services. This is something we will build on throughout and beyond this plan to ensure that we always work in genuine co-production.

We would like to thank everyone who has helped to develop this plan and who will enable the transformation to be delivered over the coming years.

**Christine Morris**
**Senior Responsible Officer: Shropshire, Telford and Wrekin LMS**

The Shrewsbury and Telford Hospital NHS Trust
Shropshire County Clinical Commissioning Group
Telford and Wrekin Clinical Commissioning Group

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# 1 Introduction to the Plan

The National maternity Review *'Better Births, The Five Year Forward View for Maternity Care'*[i] *(Better Births)* was published in February 2016. This set out a vision for transforming maternity services for women and their families across England.

Shropshire, Telford and Wrekin have established a Local Maternity System (LMS) to ensure service transformation happens at a local level. This Plan describes how the LMS will transform local maternity services by 2020/21. It will deliver the requirements of Better Births, which are to:

**Improve choice and personalisation of maternity services so that:**

- All pregnant women have a personalised care plan;
- All women are able to make choices about their maternity care, during pregnancy, birth and after their baby is born;
- Most women receive continuity of the person caring for them during pregnancy, birth and after their baby is born;
- More women are able to give birth in midwifery settings (at home and in midwifery units)

**Improving the safety of maternity care so that all services:**

- Have reduced rates of still birth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030 as outlined in NHS England's 'Saving Babies Lives, A Care Bundle for reducing stillbirth'[ii].
- Are investigating and learning from incidents and sharing this learning through their LMS and with others;
- Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement Programme.

**BETTER BIRTHS VISION**

**"Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.**

**And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."**

## 2 Our Vision

More **Women** and their families will:

- Be healthier during their pregnancy and will have a better understanding of how to keep themselves and their baby healthy
- Have better information about pregnancy and parenthood that is personal to their circumstances
- Have support with their emotional wellbeing throughout their pregnancy and after their baby is born
- Have more choice in the care they receive and will feel involved in decisions about their care
- Be able to access a wider range of services closer to home
- Know the midwife caring for them throughout pregnancy, birth and after the baby is born
- Give birth in a midwifery led setting
- Be involved in how services are designed and delivered



**Staff** will…

- Feel proud of the services they deliver
- Work within a learning culture and receive regular training alongside those they work with
- Be well supported by service leaders
- Act as advocates for the women they care for and feel empowered to deliver great service

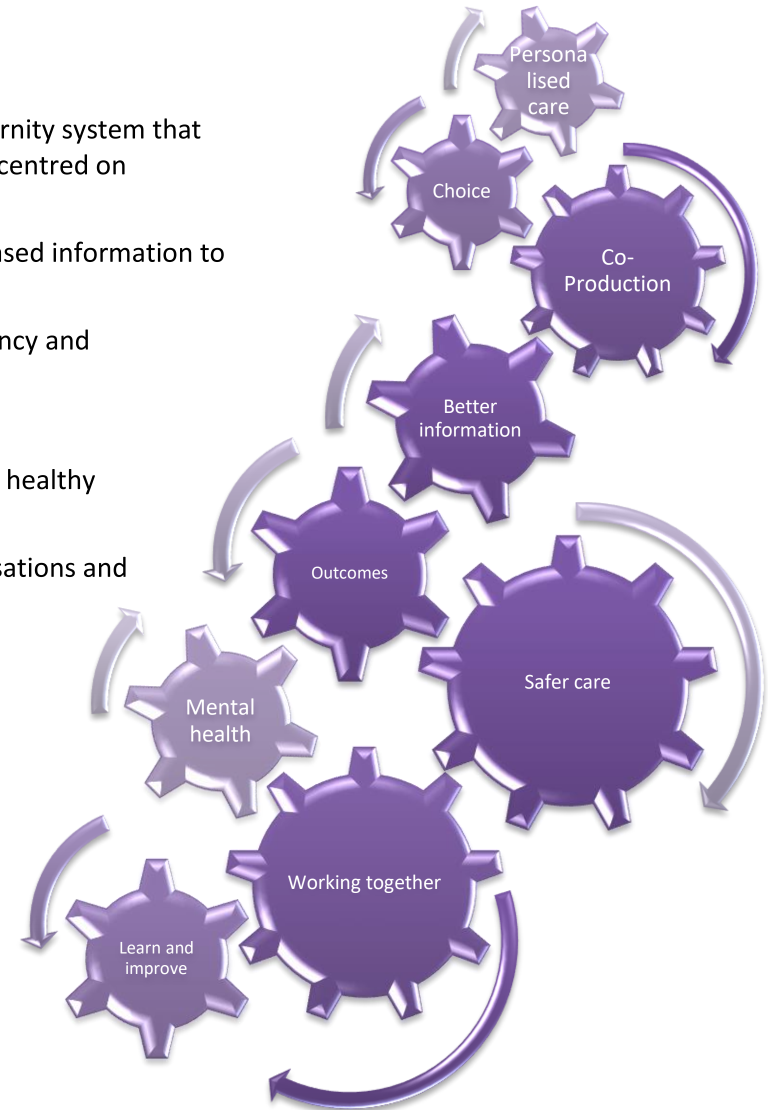
**Services** will be…

- Safer
- Designed and delivered in partnership with women and their families
- Working better together through community hubs
- Constantly learning and improving
- Sharing more information with each other

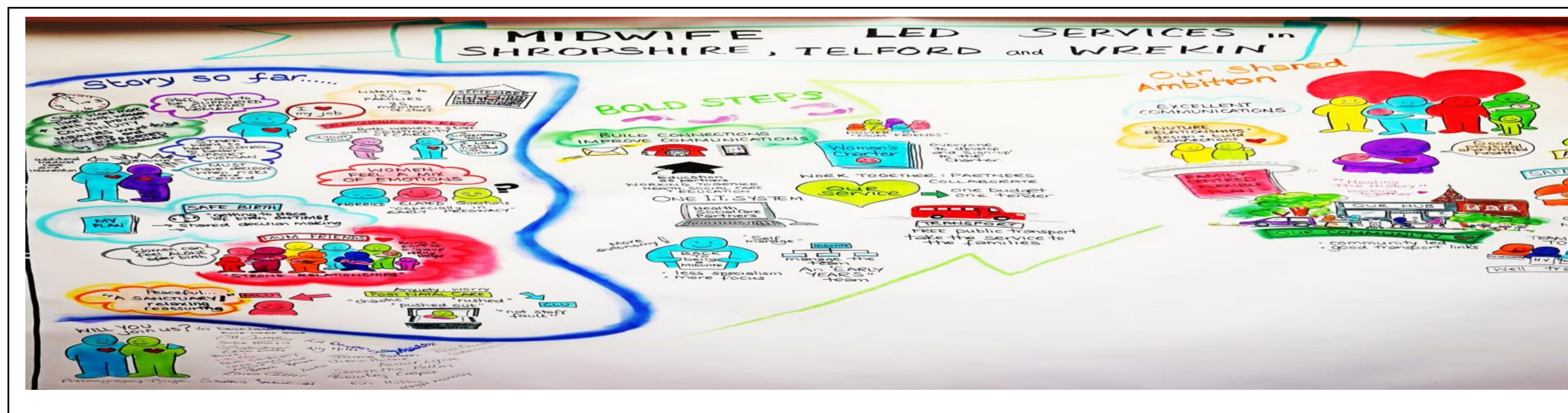
# 3 Our Pledge

## We will:

- Work together as stakeholders in true co-production to design and deliver a local maternity system that provides women and their families with a safe, quality service that is personalised and centred on individual needs and circumstances.
- Ensure every woman has a personalised care plan. Women will be able to access unbiased information to help them make decisions about their care from a range of available choices.
- Ensure every woman knows the midwife who will deliver their care throughout pregnancy and once their baby is born.
- Ensure most women know the midwife who will deliver their care during labour.
- Ensure all women of child bearing age understand how and have the opportunity to be healthy and well before, during and after their pregnancy.
- Deliver safer care. We will improve protocols between professionals and across organisations and will evidence that we continuously improve services and learn from our experiences.
- Improve access to perinatal mental health services so that all women can access support with their emotional wellbeing.
- Improve consistency and availability of postnatal care.
- Ensure that those who work together train together. We will improve how professionals work together and learn from each other.
- Improve outcomes for women and their families by working together across health, social care and early help services.



# 4 Co-Production, Leadership and Governance




## The Shropshire, Telford and Wrekin LMS is committed to co-production[iii].

This means that we strive to always work in partnership with a range of stakeholders in designing and delivering services, including those who receive or may receive maternity care.

We have developed this LMS plan in partnership with stakeholders to ensure the vision we propose is realistic. However, we know that we need to develop co-production even further and is something we will strive to do, embedding co-production at the heart of all activity as this plan is progressed. Co-production will become 'business as usual' by 2020/21.

We have started our co-production journey through the review of midwife-led services. Those who have used services, have an interest in midwifery led services and professionals working in or with midwifery led services have worked together with commissioners to start to design a future model of midwifery led care.

The image at the top of this section is the start of an illustration showing the ideas and thoughts of those who have used services, have an interest in midwifery led services and professionals working in or with midwifery led services about midwifery led services in Shropshire, Telford and Wrekin. This will be completed once all the service design workshops have taken place.

Co-production is a concept, rather than a single action. It is a way of working that brings professionals and those who use services together as equal partners in designing and delivering services. The midwife-led unit review, which is a key element of service transformation for maternity services, has been undertaken in co-production. However, in order for co-production to be fully implemented at all levels, further development will take place through the work of the LMS to embed a culture of co-production across the Shropshire, Telford and Wrekin Local Maternity System. This will involve:

- Formalising an understanding across the LMS on what co-production is and the principles that will guide its implementation
- Embedding a co-production ethos at all levels (LMS, Organisational, Service Delivery)
- Reviewing the effectiveness of the co-production approach, including :
    - the co-production process itself and how well everyone works together
    - social, wellbeing and environmental outcomes
    - the full costs and benefits, including added value

1

iv

**The LMS will use a jigsaw model for the management of change, to ensure that co-production is effective at all levels.**

The LMS will aim to have co-production embedded by 2021. To achieve this, new relationships between staff and people who use services will be developed where people who use services are recognised as experts in their own right. There will be respect for the experience and skills that everyone brings to the process and an emphasis on all the outcomes that people value, rather than just those, such as clinical outcomes, that currently the LMS organisations most commonly measure.

[1] For further information please see Appendix 8

The development and delivery of this plan is overseen by the Shropshire, Telford and Wrekin (LMS) Programme Board. The Shropshire, Telford and Wrekin LMS Programme Board is accountable to the Shropshire, Telford and Wrekin Sustainability and Transformation Plan (STP) Board.[v] The diagram below shows the governance structure for ensuring maternity transformation is delivered.

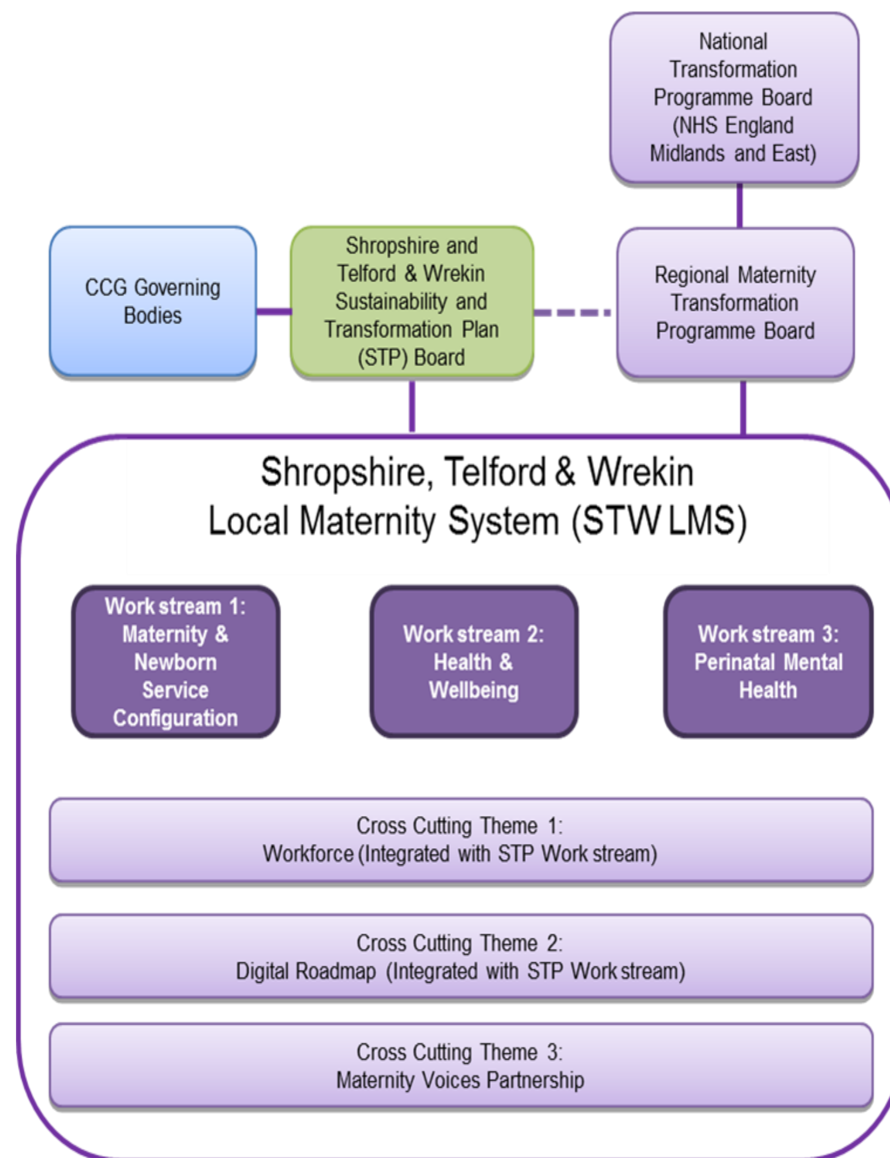
**Statement from STP Chair**

As Chair of the STP, one of the things that has struck me since I moved to Shropshire is the commitment and vitality within communities in support of their local health services. There is a strong sense across the county that people recognise what we do well and equally there is a shared understanding of where we must go further to transform the experience, sustainability, quality, safety and outcomes that we offer our patients.

The transformation of maternity services is part of the broader Sustainability and Transformation Plan (STP) of one health care system working together. Any changes will rightly be influenced by the knowledge and experience of mothers and their families. Some of whom we have already cared for and some we will care for in the future.

This LMS plan will therefore look forward to ensure that we provide a state of the art maternity service that uses the digital and technological advances that will support a modern workforce for the years to come.

*Simon Wright: STP Chair*



The LMS Programme Board will ensure the required transformation is achieved through the work of three workstreams and three cross-cutting themes.

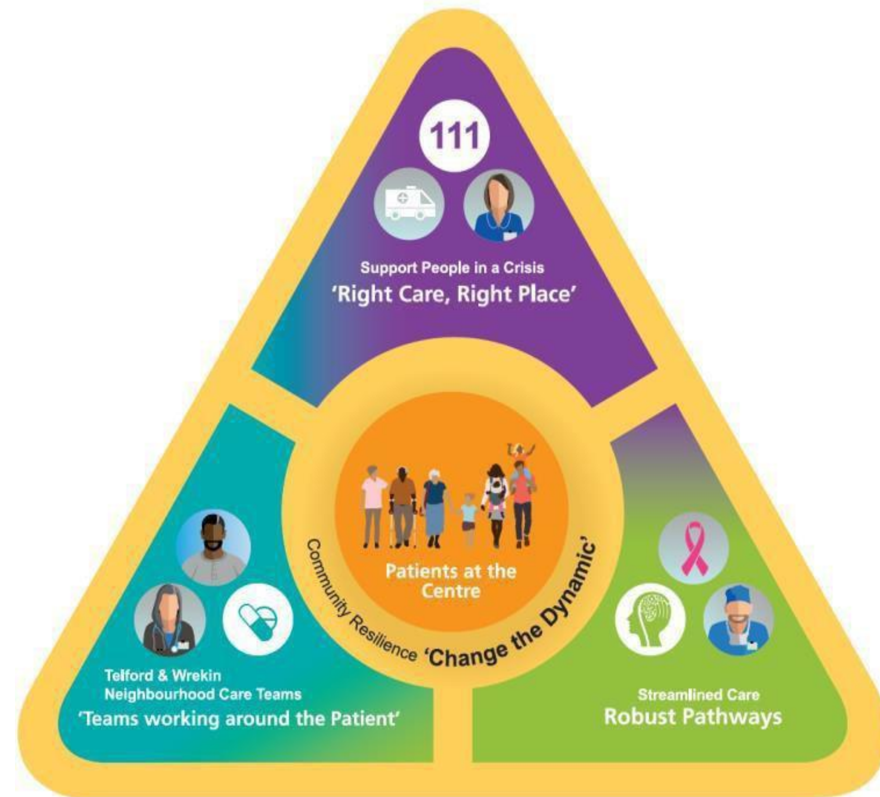
Through the governance arrangements into the STP Board, the LMS will ensure that the maternity transformation adopts all of the STP principles where appropriate, including place based care.



**Helping to deliver the STP vision**

The transformation delivered through this plan is specific to maternity services. However, this will sit within the context of the broader Sustainability and Transformation Plan (STP) for Shropshire, Telford and Wrekin. In implementing this plan, consideration will be given to how the maternity transformation can support the delivery of the priorities of the STP, including the development and implementation of placed based models of care, which aims to bring care closer to home.

[2]




[2] For further information please refer to Appendix 1

## 4.1 Workstreams

### 4.1.1 <u>Workstream 1: Maternity & Newborn Service Configuration</u>

The design of maternity and neonatal services is fundamental to ensuring service transformation. This workstream will look at what needs to change so that maternity and neonatal services offer the level of choice, personalisation and safety that Better Births requires.

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### 4.1.2 <u>Workstream 2: Health and Wellbeing</u>

Maternity and neonatal services care for women and their babies during pregnancy, birth and in the early days after birth. However, enabling women and their families to live healthy lives needs much more than this. This workstream will focus on the transformation that needs to take place to enable women and their families to lead healthier, happier lives in the longer term. Partners across the health economy will work together to implement strategies and services to improve women's health before, during and after pregnancy as well as the health of their babies.

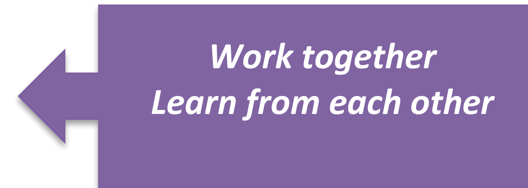
### 4.1.3 <u>Workstream 3: Perinatal Mental Health</u>

This workstream will transform services so that women and their families have much better access to information, advice and services to support them with emotional health and wellbeing during pregnancy and after their baby is born. Professionals will also have a better understanding of perinatal mental health.

## 4.2 Cross-cutting Themes

**4.2.1** **Cross-cutting Theme 1: Workforce**

To enable the required transformation to occur, there needs to be significant changes to the existing workforce. This workstream will deliver improvements to the culture, skills and availability of the workforce.




**4.2.2** **Cross-cutting Theme 2: Digital Roadmap**

A key focus of Better Births is around improving the use of technology in the delivery of maternity services. Through the Sustainability and Transformation Plan, this workstream will seek to implement technological improvements for women and their families as well as professionals in order to support the transformation required.

**4.2.3** **Cross-cutting Theme 3: Maternity Voices Partnership**

The maternity voices partnership is responsible for ensuring that stakeholders, including women, their families and professionals always work together in designing and delivering maternity services. It will also improve communication between women and their families with professionals in relation to maternity services.

## 4.3 Delivery and Assurance

The LMS transformation programme will be monitored, assured and evaluated through measures that will evidence delivery against outcomes for women and their families, babies and staff.

A baseline self-assessment against the recommendations outlined in Better Births has been undertaken. [3]This will be updated throughout the life of the plan to evidence progress in transformation. The table below sets out the current position and projected improvements against key measures associated with delivering the requirements of Better Births.

Further detail about how the improvements will be delivered is contained within the 'Delivering the Vision' section of this plan.



**Shropshire, Telford and Wrekin Local Maternity System – Improvement Plan**

| Area of Improvement | Position 31.03.2017 | Target 31.03.2018 | Target 31.03.2019 | Target 31.03.2020 | Target 31.03.2021 |
|---|---|---|---|---|---|
| **Stabilised and adjusted rate of stillbirth (3 year rolling average)** | 4.0/1000 (2013-2015 average) | 3.7/1000 | 3.4/1000 | 3.2/1000 | 3.0/1000 |
| **Stabilised and adjusted rate of neonatal death (3 year rolling average)** | 1.6/1000 (2013-2015 average) | 1.5/1000 | 1.4/1000 | 1.3/1000 | 1.2/1000 |
| **Rate of direct maternal death** | To be confirmed (5 year average) | n/a[4] | n/a | n/a | n/a |
| **Rate of intrapartum brain injury** | 2.1/1000 (HIE rate[5]) | 1.9/1000 | 1.8/1000 | 1.7/1000 | 1.5/1000 |
| **% of women with personalised care plans** | 0% | 0% | 100% | 100% | 100% |
| **% women booking before 12 weeks 6 days gestation** | 87.7% | 91% | 94% | 96% | 98% |
| **% women booking before 9 weeks 6 days** | 41.6% | 45% | 50% | 55% | 60% |
| **Choice available for[6] antenatal care** | Measure in development | Measure in development | Measure in development | Measure in development | Measure in development |

[3] Further information on the self-assessment can be found in Appendix 10

[4] Work is underway to develop measures that will evidence improvements in reducing the likelihood of maternal deaths and improving investigations

[5] Hypoxic Ischemic Encephalopathy is a reduction in the supply of oxygen to the brain and other organs (hypoxia)

| % women able to choose from 3 places of birth | 100% | 100% | 100% | 100% | 100% |
|---|---|---|---|---|---|
| % women able to choose from 4 places of birth | 100% | 100% | 100% | 100% | 100% |
| Choice available for postnatal care | Measure in development | Measure in development | Measure in development | Measure in development | Measure in development |
| % women who have continuity of carer throughout antenatal and postnatal care | 85% | 90% | 95% | 98% | 99% |
| % women who have continuity of carer throughout antenatal, intrapartum and postnatal care | Measure in development | Measure in development | 20% | 25% | 30% |
| % women giving birth in midwifery led settings including home birth | 14% (688/4928) | 15% | 17% | 20% | 25% |
| Increase in investment in Perinatal Mental Health Services | £27,000 | £27,000 | To be confirmed pending funding bid | To be confirmed. Awaiting amount of increased funding in CCG Baselines | To be confirmed. Awaiting amount of increased funding in CCG Baselines |
| Number of new women seen by Perinatal Mental Health services | | | 96 | 240 | 360 |
| Increase in the number of women reporting they are confident in | Measure in development | Measure in development | Measure in development | Measure in development | Measure in development |

[6] Through working in co-production we will define what we mean by choice in antenatal care and choice in postnatal care, identify the current baseline and project our improvements over the course of transformation.

managing their
emotional health and
wellbeing

# 5 Patient Safety and Quality of Care

The safety of mums to be and their babies is the most important factor in delivering maternity services. The performance of service providers is monitored to ensure services are delivering appropriate, safe, quality care that is delivered at the right time.

In Shropshire, Telford and Wrekin each commissioning organisation (organisations that are responsible for planning and purchasing services for their local population) has processes in place to monitor the performance and quality of the services. These processes have recently been strengthened through the introduction of a separate Contract Quality Review Process for maternity services in Shropshire, Telford and Wrekin. In delivering this plan, the monitoring of performance, quality and safety will be further improved through the introduction of a quality and safety improvement system across the whole LMS.

[7]



**Serious Incidents**

Serious incidents in healthcare are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant particular attention. It is important that these events are reported on and investigated so that we can respond appropriately when things go wrong. This is a key part of the way that the we can continually improve the safety of the services provided and commissioned. The underreporting of safety events is often noted to be the result of an unfavorable culture that attributes 'blame' when things go wrong. In partnership, we wish to enable a safety culture to flourish reinforcing safety as our top priority. Ultimately, by reporting and investigating incidents, complaints and concerns, staff will be more confident in the care they provide and we will be better able to identify gaps in processes. This can only be achieved through good leadership, by building a shared vision and by helping everyone feel safe and accountable and proud to work within a supportive learning culture. The steps we will take to achieve this will be included in the Quality and Safety Improvement Framework.

Between April 2014 and October 2017 there have been 15 serious incidents reported (as defined by NHS England's serious incident criteria). Themes identified include:

- Monitoring babies' heart beats effectively before they are born
- Understanding changes to pregnant women's risk factors
- Ensuring babies are born in a place that can best meet their needs

Other incidents that are not categorised as serious incidents are thoroughly reviewed using a high risk case review process to ensure learning is identified and changes in practice are implemented. Through the transformation of maternity services, we will improve the way that we investigate and learn from incidents to help reduce the risk of similar incidents happening again. We will improve the way that we communicate and work with families when outcomes are not as expected.

[7] Further information on safety and quality of maternity services in Shropshire, Telford and Wrekin can be found in Appendix 6

## Saving Babies' Lives

Partners within the LMS have developed and implemented a number of initiatives in order to improve safety of services in line with the requirements of the national Saving Babies' Lives initiative, which was launched in 2016. Saving Babies' Lives is designed to reduce stillbirth and early neonatal death. It brings together four elements of care in order to achieve the required reduction. The boxes below describe the improvements that have been made to date and the further work that will be delivered through maternity transformation.

### Reducing smoking in pregnancy

Currently:

- All women are asked about their smoking status at booking.
- Women who are smoking at booking or have recently stopped are referred (unless they opt out) to the smoking cessation service.
- All women are offered a carbon monoxide test booking.
- All women should discuss smoking at each clinical contact.

Additional activity through maternity transformation:

- Smoking cessation services will be held alongside local antenatal services. This will allow women to attend both appointments on the same day in the same location.



### Raising awareness of reduced fetal movement

Currently:

- All women are provided with a leaflet highlighting the importance of identifying reduced fetal movement at the start of the third trimester.
- All women are reminded of the importance of monitoring fetal movements throughout the third trimester.
- All women are encouraged to attend their local maternity unit for assessment and monitoring if they experience reduced fetal movements.
- Monitors, with on-board electronic analysis, are located in all of the midwife led units and the consultant unit.

Additional activity through maternity transformation:

- There will be investment in better equipment, which is standardised.

### Risk assessment and surveillance for fetal growth restriction (FGR)

Currently:

- Women at highest risk of FGR are offered a number of ultrasound scans in the third trimester depending upon their level of risk. The service standards currently offered are not in line with guidance.

Additional activity through maternity transformation:

- Partners within the LMS will work together to achieve service standards in line with Saving Babies' Lives guidance.
- Ultrasound scan locations will be targeted to areas of high need across the STP footprint.
- Detection rates will be assessed using the new software (called GAP) in order to monitor the effectiveness of the service.

### Effective fetal monitoring during labour

Currently:

- All staff members required to assess Cardiotogographs (CTG – the machine which monitors the baby's heartbeat and movements) are regularly trained in CTG interpretation

Additional activity through maternity transformation:

- Intrapartum CTGs (CTGs taken during labour) will be archived electronically for review and teaching.
- Intrapartum CTGs will be displayed live outside the labour room in order for staff to assess using fresh eyes on a regular basis throughout labour.
- There will be investment in better equipment, which is standardised.

**Maternal and neonatal health safety collaborative**
This is a 3 year national programme to support improvement in the quality and safety of maternity and neonatal units across England. The overall aim of the programme is to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030. The LMS are engaged with the collaborative and SaTH will join the collaborative in April 2018.

Joining the collaborative will help with building our capability in quality improvement and will provide us with structured support to develop innovative plans that lead to measurable improvements.

**Sign up to Safety**

A safety improvement plan has been in place since 2015. This has led to a number of safety improvements to date including enhanced training for professionals and investing in better equipment.

The findings from the external reviews that are currently ongoing will inform further developments in this area.

The National Maternity Safety Strategy published in November 2017 set out the Department of Health's ambition to reward those who have taken action to improve maternity safety, including a CNST incentive scheme. Clinical Negligence Scheme for Trusts (CNST) is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts in England currently belong to the scheme. For SaTH maternity services as a whole, the cost of this is nearly £5.8million per year.

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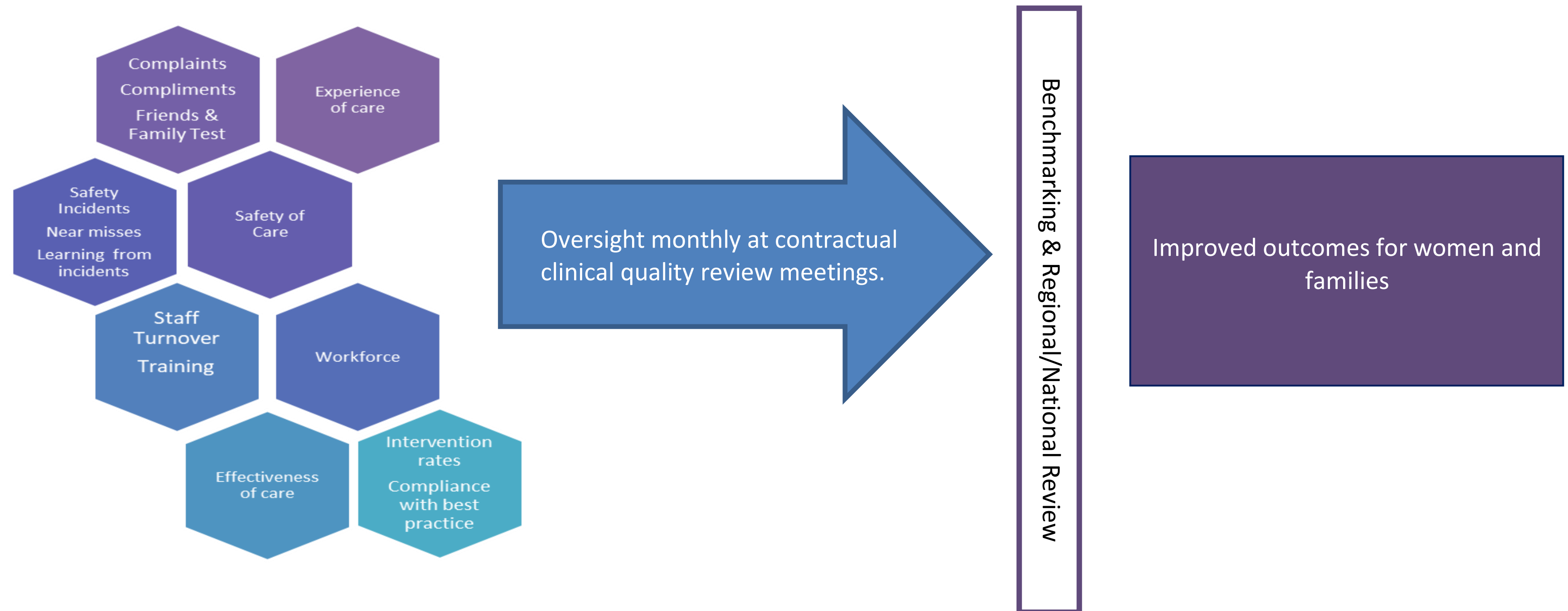
For 2018/19, SaTH will be submitting evidence of delivery of each of the 10 criteria in the CNST incentive scheme in order to receive a 10% reduction in CNST rate. This will release in the region of £580,000 which can be re-invested in safety improvement activities within maternity services. The ten safety improvement criteria that will be met are:

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?
4. Can you demonstrate an effective system of medical workforce planning?
5. Can you demonstrate an effective system of midwifery workforce planning?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'inhouse' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

**In order to gain assurance, performance on services delivered is measured against quality indicators for maternity. In 2016/17, the services for Shropshire, Telford and Wrekin were within the expected range and in line with national performance. The diagram below illustrates the information considered as part of this process.**

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## 5.1 Safeguarding

Safeguarding is of paramount importance to all services provided across Shropshire, Telford and Wrekin. Throughout the LMS, safeguarding will be the 'golden thread' throughout all workstreams and cross-cutting themes.

Processes are compliant with CQC best practice and national directives and reviewed on a frequent basis both across the LMS and by external agencies. All partners across the LMS work effectively in the interests of the child and adult.

Actions are currently being implemented across the maternity service that enhances safeguarding based on the recommendations outlined in the 2017 CQC report 'Review of Health Services for Children Looked-after and Safeguarding in Telford and Wrekin'[vi]. All actions are monitored via clinical quality review meetings to provide assurance regarding progress made.

Local safeguarding arrangements within maternity services include:

- ✓ Maternity Safeguarding Alert System
- ✓ Named midwife for safeguarding
- ✓ Specialist midwives for:
  - vulnerable women
  - bereavement
  - public health
  - young mothers
- ✓ Safeguarding and supporting women with additional needs group (SSWWAN)
- ✓ Named doctor and neonatologist are members of child death overview panel
- ✓ Teenage safeguarding pathway
- ✓ Strong links to multi agency safeguarding hubs
- ✓ Mandatory safeguarding training and supervision
- ✓ Safeguarding audits and links to local safeguarding boards

Shropshire, Telford and Wrekin have safety at the forefront of all planning and delivery of maternity services

All actions taken will improve the quality of care, providing seamless care to women and their babies across organisational boundaries and will provide personalised care to each woman, her baby and family

**Safeguarding will be the 'golden thread' throughout the LMS**

Concerns raised by service users will be heard and acted upon by whoever receives the issue anywhere across the LMS, and when things do go wrong, there will be swift learning taken following a high quality investigation

Greater continuity of care will be provided through visible multi-professional leadership, improving and integrating pathways that progress outcomes, including prevention, mental health, neonatal and postnatal care all accessible through a Community Hub Model

# 6 About Shropshire, Telford and Wrekin

The county of Shropshire has borders with four English counties as well as having the English/Welsh border to the west. Therefore, in planning maternity transformation it is important to consider the needs of those accessing services in Shropshire, Telford and Wrekin as well as women from Shropshire, Telford and Wrekin who access services over the borders.

Shropshire Clinical Commissioning Group (CCG) covers a large geography with issues of physical isolation and low population density within a mix of rural and urban ageing populations. Shropshire is a large rural county with a population of approximately 308,000 that is set to rise to 320,600 by 2020.

Telford & Wrekin CCG has a large, younger urban population within areas of rurality. Telford is ranked amongst the 30% of most deprived populations in England. The population is approximately 170,000 and due to grow to 198,000 by 2031; the percentage of people who are aged over 85 is set to increase by 130%. Telford and Wrekin has a higher proportion of households with dependant children than the national average and a lower proportion of households where all residents are aged over 65.

[9]

The Shropshire, Telford and Wrekin health and social care economy comprises two CCGs, four main NHS providers, two Councils and a range of smaller private and third sector providers.

The overall population within the footprint is approximately 480,000 people, but a number of outlying populations, most notably Powys, access services at providers within Shropshire; whilst Powys is not officially part of the LMS footprint, we believe it is important to include the Powys population in the LMS and for the community to be represented on the LMS Board.

[9] Further information about the demographics of the county can be found in Appendix 1.

As a large rural area, access to services is an important consideration in planning and designing services. This image shows the journey times to the two main hospitals from across the area. Patients using public transport may have significantly longer journey times.

# 7 Current Offer

## 7.1 Before getting pregnant

Across Shropshire, Telford and Wrekin a range of services are on offer to support people before getting pregnant. Healthy Lifestyles Services (Telford & Wrekin) and Help 2 Change (Shropshire) offer free advice, information and support around health and lifestyles to enable individuals to feel better, healthier and have more energy. They offer support and help around eating healthily, being more active, reducing alcohol consumption, stopping smoking and feeling better about yourself.

Contraception, sexual health and family planning clinics are available across the county to support planned pregnancies. In addition, specialist services are available within the county to help couples conceive (fertility services) and provide them with pre-conception advice (maternity services).

Women can access information, advice and support in relation to their mental health through local mental health services and their GP.



## 7.2 Care before the baby is born (antenatal care)

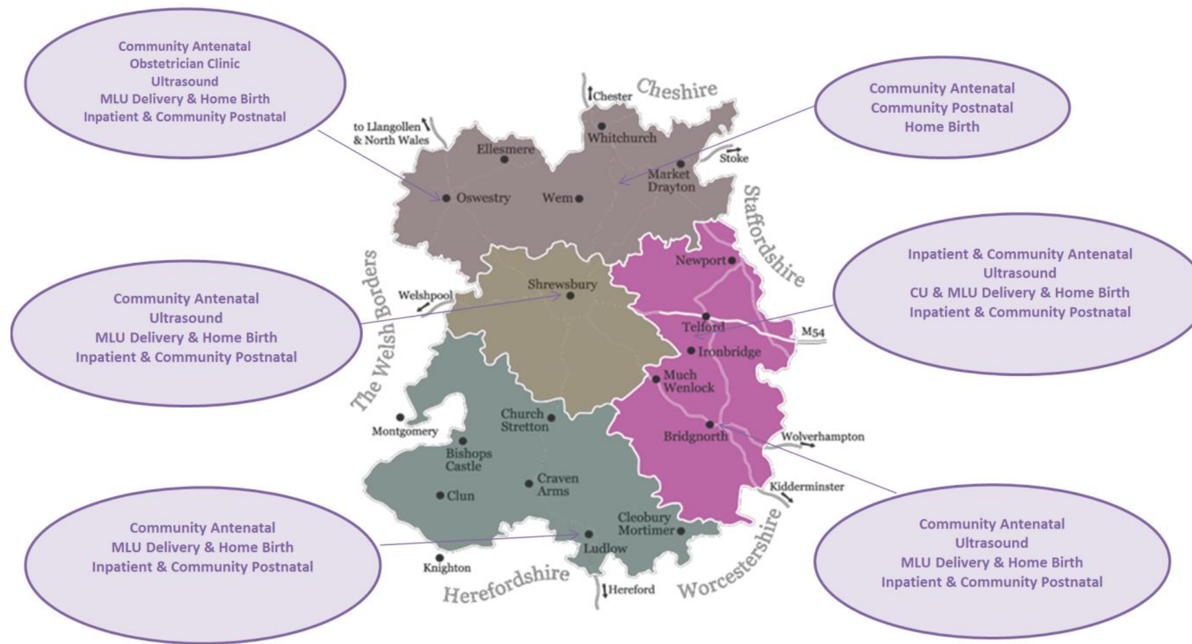
Around 5,500 women book to receive maternity services with the maternity services provider in Shropshire, Telford and Wrekin (Shrewsbury and Telford Hospitals Trust – SaTH) each year. The majority of routine antenatal care is delivered by community midwives. The smaller community teams have between 200-400 attendances a month, with the larger community teams having approximately 2,500 attendances a month.

Women have a hand-held record within which professionals document their antenatal care. Women take this document with them to appointments for the professionals to update.

Women are referred to maternity services in one of two ways – through their GP or by referring themselves through one of the midwife led units. Booking directly with the midwife led units is quicker, but essential information that the GP holds may not be shared. Women can choose how they access routine antenatal care. Women can access antenatal care at one of the 5 midwife led units, a clinic at their GP practice or through the midwife visiting them at home. Women with a higher level of need can access obstetric care through clinics at Princess Royal Hospital or Royal Shrewsbury Hospital. There are also obstetric clinics held in Ludlow and Oswestry midwife led units.

[10]

[10] For further information please refer to Appendix 2.6




This map shows which elements of service are available in different parts of the county. Through implementing Workstream 1, there will be more equity across the county with regards to the types of services available in the community.



- ✓ Women can access information online via the SaTH website and maternity apps.
- ✓ Women have continuity of carer during pregnancy. Community midwives work in small teams of 4-6, so women are likely to know the midwife they see during their pregnancy.
- ✓ Women can access specialist joint obstetric mental health clinics, which are held fortnightly.
- ✓ Women can access psychological therapies through the IAPT service.
- ✓ Most women who require in-patient care because of their mental health needs during pregnancy or in early motherhood, access services from the Brockington Unit in Stafford. The service provides assessment, treatment and care for women suffering from mental health problems associated with pregnancy and childbirth including severe postnatal depression and puerperal psychosis.

Across the county there is support to stop smoking during pregnancy through Help2Quit (Shropshire) and the Public Health midwifery service (Telford and Wrekin). Women access the service via a referral at booking (unless they opt out) and can also be referred to the service throughout their pregnancy by midwives and sonographers, as well as accessing the service through self-referral. All midwives and women support advisors receive annual training about smoking during pregnancy as part of the annual statutory training programme delivered by the public health midwife.

In Telford and Wrekin, a support programme is offered to all women with a BMI greater than 30 at booking. The service is called 'Healthy Mums' and offers support during pregnancy and after delivery until the child is 6 months old. The programme aims to support women to maintain a healthy weight gain during pregnancy and supports weight loss after delivery. Currently 71% (2016-17) women gain no more than the healthy 10kg during their pregnancy. In 2016-17 the service was averaging 52 referrals per month.



## 7.3 Giving Birth (Intrapartum Care)[11]

Women have a range of options in relation to where they choose to give birth in Shropshire, Telford and Wrekin. These are:

- 1 x Consultant Unit (CU) (Telford – Princess Royal Hospital)
- 1 x Alongside Midwifery Led Units (MLU) (on the same site as the consultant unit)
- 4 x Freestanding MLU (not on the same site as consultant unit – Shrewsbury, Oswestry, Bridgnorth, Ludlow)
- Home birth

Women giving birth in the consultant unit are not likely to know the midwife or doctor delivering their baby. However, those giving birth in a midwife led unit or at home are likely to know the midwife caring for them during labour.

Women who wish to use a different service provider for their care in labour can request funding from the Clinical Commissioning Group.

[11] Where numbers are given for 'births', this is the number of babies born. Where numbers are given for 'deliveries' this is the number of women who have given birth e.g. if a woman has twins, this will be one delivery but two births.

## 7.4 Care after the baby is born (postnatal care)

After giving birth, women and their babies receive care at one of the inpatient postnatal units or in the community. Women are likely to know the midwife providing their postnatal care. The midwife is likely to be one of the same midwives who provided care for the woman during her pregnancy. Once the baby is 10 days old, the midwives hand over the care to the Health Visiting Team. Some young vulnerable mothers will continue to be supported through the Family Nurse Partnership. Health visitors are trained to support women with their mental health needs and women can access more specialist services in the community or as an inpatient if they need to.

Both Shropshire and Telford & Wrekin offer a breastfeeding service. Shrewsbury and Telford Hospitals have been awarded the full UNICEF baby friendly Initiative, as well as Shropshire Children Centres. Across the county there is breastfeeding support offered by health visitors, breastfeeding facilitators and volunteers.

Both Telford & Wrekin Council and Shropshire Council commission 0-19 services including Health Visiting, School Nursing and Family Nurse Partnership. They offer a range of services to support during pregnancy and being a parent. They offer mandated visits for all women antenatal and postnatal at 10-14 days, 6-8 weeks, one year and two years. They also offer additional support, help and advice for families classed as targeted, vulnerable and complex. They offer support on a variety of areas such as breastfeeding, weaning, healthy eating, sleeping and parenting.



## 7.5 Care for new-born babies (neonatal care)

The majority of babies that are born are healthy and remain with their mother. During the first few days of their life, they are cared for by midwives who support their mother in the general care of the baby. Screening examinations of the babies are carried out by the midwives either in the hospital or community setting.

A proportion of babies will require an increased level of care provided by neonatal staff from the Neonatal Unit (NNU). The Neonatal Unit within the Shrewsbury and Telford Hospital (SaTH) is a Local Neonatal Unit (LNU). This is defined by British Association of Perinatal Medicine as: providing special care and high dependency care and a restricted volume of intensive care (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit (NICU). The two closest NICUs are located at the University Hospitals of North Midlands in Stoke and New Cross Hospital in Wolverhampton.

SaTH Maternity and Neonatal department completed a successful project in 2017 around the investigation of babies admitted to the NNU at term (i.e. not premature) and the possible ways to reduce the number of such admissions. Since then a range of professionals meet regularly to examine the background to babies admitted to the neonatal unit at term. The group are using the template suggested by the national ATAIN Programme (avoiding term admissions into neonatal units), which is led by clinical experts, to ensure their work is robust.

# 8 What do we know about the needs and preferences of women and the needs of their babies?

## 8.1 What women and their families say is important to them

During summer 2017, the views of women and their families in relation to maternity services were gathered and considered. This involved looking at existing feedback that the CCGs, SaTH and HealthWatch had received as well as gathering new information about what women and their families said was important to them. [12]

Existing feedback shows that in general women and their families are happy with the services they receive. Women and their families say that the following things are important to them:

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[12] For further information on the views of women and their families please see Appendix 8.1

## 8.2 What does our data tell us? [13]

Across Shropshire, Telford and Wrekin there are an estimated 78,700 women of a child bearing age (16-44 years). Projections indicate that the numbers of women of childbearing age will be relatively static. Projections also indicate that the proportions of the population which are aged 0-4 years old will remain broadly similar in Telford, Wrekin, and Shropshire in 2025 and 2035.

In Shropshire there are on average 3,400 conceptions in women of all ages each year, 18% (615 conceptions) end in termination, which is lower than the national average. In Telford and Wrekin there are on average 2,615 conceptions in women of all ages every year. Just over a fifth, 21% (550 conceptions) end in termination, which is similar to the England average (21%).

In Telford and Wrekin, a total of 367 women smoked at delivery in 2015/16, compared to 295 women in Shropshire. Maternal smoking is significantly high in Telford and Wrekin. However, rates have started to decline in the past two years, falling below 20%. The rate of smoking in pregnancy in Telford and Wrekin was 18.1% in 2015/16, compared to 12.3% in Shropshire and 10.1% in England as a whole.

In 2014 in Telford and Wrekin the rate of under 18 conceptions was significantly higher than the England average and double the rate in Shropshire. Teenage conception rates in Telford and Wrekin have historically been significantly higher than the England average, whereas in Shropshire rates have been significantly lower.



In Telford and Wrekin, over a quarter women aged 16-44 years live in communities classified within the most deprived fifth of areas in England. This compares to 5.8% in Shropshire.

It is estimated that 71% of all adults in Telford and Wrekin carry excess weight (i.e. overweight or obese). This is significantly worse than the national average of 64.8%. It is estimated, that circa 22,250 women of child bearing age (15-44 years) carry excess weight in Telford and Wrekin. In Shropshire 65.2% of all adults are estimated to be overweight or obese, which is not significantly different to the England average.

Levels of breastfeeding (both initiation at birth and duration at 6-8 weeks) have been historically low in Telford and Wrekin, but rates have improved slowly. In 2015/16 almost a third, 33.5% of infants (655 babies) were not breastfed at birth, which is significantly worse than the average for England 25.7%. In Shropshire just under a quarter, 24.7% of infants (605 babies) were not breastfed at birth in 2015/16, which is similar to the national average. By 6-8 weeks of age breastfeeding has dropped further. In 2015/16 63.7% of infants were not receiving any breast milk in Telford and Wrekin (2,044 babies), which is significantly worse than the England average of 56.8%. In Shropshire 54.1% of infants (2,771 babies) were not breastfed at 6-8 weeks.

[13] For further information please refer to Appendix 2.1,2.5,2.5,3.1,3.2,3.3,3.4,3.7,5.1

Trends in infant mortality rates fluctuate due to the small number involved, but since the mid 1980s in Shropshire, Telford and Wrekin rates have been declining overall across the decades. The three year rolling average rates have been significantly higher than the England average for the past five years.

There are a similar number of perinatal deaths (stillbirths and deaths before 1 week) in Shropshire, Telford and Wrekin – on average 17 per year and rates are similar to the England average.

There are on average 2,100 live births in Telford and Wrekin each year, compared to on average 2,820 in Shropshire. There are on average 10 neonatal deaths within the first 4 weeks of life in Telford & Wrekin. The neonatal mortality rates in Telford & Wrekin from the period 2012-14 and 2013-15 were significantly worse than the England average. In Shropshire there are on average 6 neonatal deaths per year and rates are similar to the England average.

Of the women accessing SATH maternity services in 2016/17, 85.1% gave birth in the Consultant Unit at Princess Royal Hospital. This is in line with the findings of the national maternity review[1] (87% women nationally give birth in a consultant led unit). Most women in Shropshire, Telford and Wrekin give birth within the county. However, some women choose to give birth out of county. These are normally women living on the borders. The most frequent out of area hospitals accessed by Shropshire, Telford and Wrekin women to deliver are Wrexham Maelor, Worcester Royal Hospital and Hereford County Hospital.

Shrewsbury and Telford Hospitals Trust (SaTH) have around 5,000 births each year. Over 92% births are in relation to Shropshire, Telford and Wrekin patients, the remaining births are of patients from elsewhere. The number of babies born in Shropshire, Telford and Wrekin is summarised in the table.

14

**SATH Maternity Services : Births 2016/17**

| Maternity Unit | Shropshire Patients | Telford & Wrekin Patients | Powys Patients | Patients from other areas |
|---|---|---|---|---|
| Consultant Unit | 2,016 | 1,830 | 216 | 132 |
| Shrewsbury MLU | 142 | 0 | 0 | 0 |
| Wrekin MLU | 135 | 199 | 0 | 3 |
| Bridgnorth MLU | 67 | 2 | 0 | 8 |
| Oswestry MLU | 50 | 0 | 0 | 2 |
| Ludlow MLU | 31 | 0 | 0 | 5 |
| Home | 41 | 21 | 1 | 1 |
| Born before arrival (without presence of midwife or obstetrician)/other | 8 | 8 | 2 | 8 |
| **Total** | **2,490** | **2,060** | **219** | **159** |
| **Total Births 2016/17** | **4,928** | | | |

**The number of births are projected to remain relatively static during the transformation timescale, with births projected to be 4,989 in 2020/21**

14 For further information please refer to Appendix 2.1,2.6

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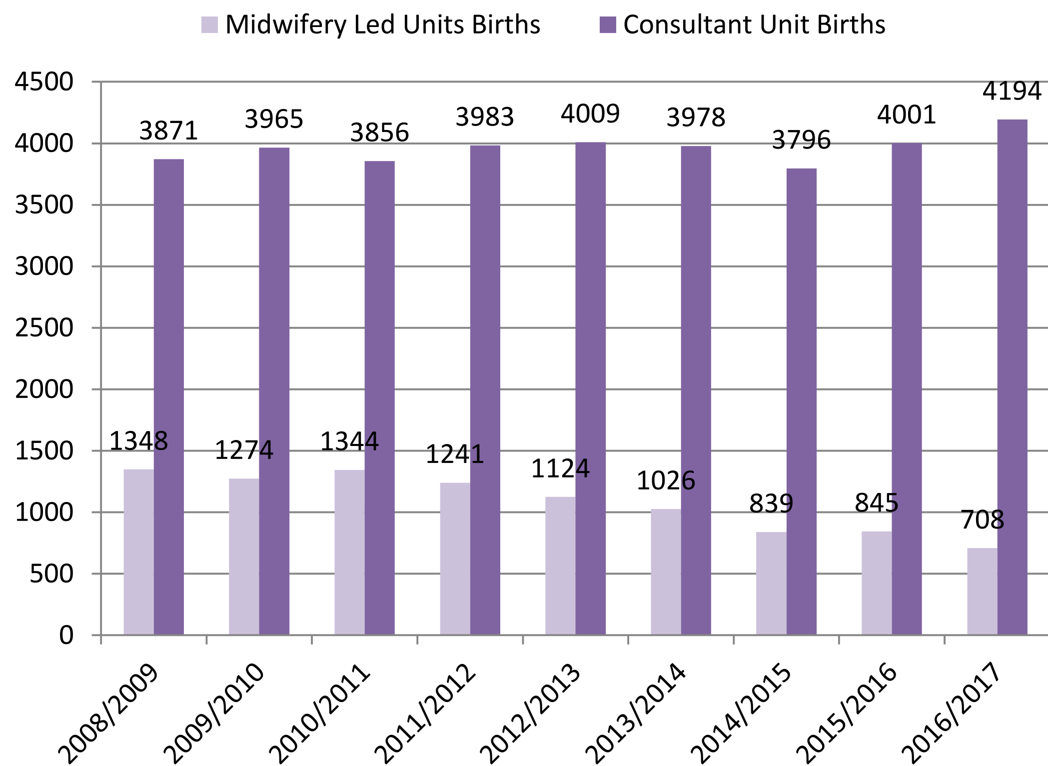
Over the last nine years, the births within the midwife-led units or at home have steadily declined from approximately 1,350 (26% of total activity) to 708 (14% of total activity), as illustrated in the graph below.

SATH Summary Birth Figures 2008-2017




In Shropshire, Telford & Wrekin, many women intend to give birth at midwife led units, but go on to deliver in the consultant unit. In 2015 and 2016, 3,921 women intended to give birth in a MLU or at home. However, only 1,498 (38.2%) of women who intended to give birth in a MLU or at home actually did so. The change of intended place of delivery most commonly occurs during the antenatal period and is usually associated with a change in risk to the mother or the baby.

Through this transformation plan we will explore how we can enable more women to have a midwife led birth.

Most women (90%) and their babies receive inpatient postnatal care on either the Postnatal Care Ward at Princess Royal Hospital, the Wrekin MLU or Shrewsbury MLU. 10% of women receive some or all of their postnatal care at either Ludlow, Bridgnorth or Oswestry MLU.

This table shows the total bed days available at the MLUs compared to the bed days used in 2016/17

| MLU | Total bed days available per year | Total bed days used 2016/17 (% utilisation) |
|---|---|---|
| **Wrekin** | 13 x 365 = 4,745 | Not available[15] |
| **Shrewsbury** | 10 x 365 = 3,650 | 647 (18%) |
| **Bridgnorth** | 4 x 365 = 1,460 | 321 (22%) |
| **Oswestry** | 6 x 365 = 2,190 | 570 (26%) |
| **Ludlow** | 4 x 365 = 1,460 | 239 (16%) |

In 2016/17 the MLUs cared for around 2,074 women in the postnatal period that gave birth on the Consultant Unit. The majority of these women were cared for postnatally at Wrekin MLU (1,406). Shrewsbury cared for 331 women postnatally, with Ludlow, Oswestry and Bridgnorth caring for 91, 106 and 140 women respectively.



On average women who have a postnatal stay, stay at the MLUs for around two and a half days. The number of women having a postnatal stay varies across the MLUs. In 2016/17 the freestanding MLUs each had approximately 5-15 women each month having a postnatal stay. The alongside MLU has a higher number of women staying each month. After leaving the hospital/MLU, women receive postnatal care from midwives in the community.

[15] Data is currently recorded by site. Information about postnatal stays specifically in the MLU was not available at the time of writing this report, as information relating to Princess Royal Hospital includes activity in the consultant unit as well as the MLU.

Estimated prevalence rates of perinatal mental health difficulties for Shropshire, Telford and Wrekin are displayed in the below table.

| Rates of perinatal psychiatric disorder | per thousand maternities | Estimated number of women affected per year – England | Estimated number of women affected per year – Shropshire (2,490 births) | Estimated number of women affected per year – Telford and Wrekin (2,060 births) | Estimated number of women affected per year – Shropshire, Telford and Wrekin (4,550 births) |
|---|---|---|---|---|---|
| **Postpartum psychosis** | 2/1000 | 1,380 | 5 | 4 | 9 |
| **Chronic serious mental illness** | 2/1000 | 1,380 | 5 | 4 | 9 |
| **Severe depressive illness** | 30/1000 | 20,640 | 75 | 60 | 135 |
| **Post-traumatic stress disorder** | 30/1000 | 20,640 | 75 | 60 | 135 |
| **Mild - moderate depressive illness and anxiety states** | 100-150/1000 | 86,020 | 250 – 375 | 200 - 300 | 450 - 675 |
| **Adjustment disorders and distress** | 150-300/1000 | 154,830 | 375– 750 | 300 - 600 | 675 – 1,350 |

# 9 Finance & Sustainability

The Shropshire and Telford & Wrekin Health Economy is currently under significant financial pressure and the Sustainability and Transformation Plan (STP) describes the significant financial challenge (£126m) that the local health system needs to address over the next 5 years. STP partners are in agreement that in order for our NHS to continue to provide services for the future, changes need to be made now.[16]

There is not enough money for us to continue as we are and we need to make changes to take full advantage of recent rapid progress in treatments and technology.

The overall reconfiguration of acute hospital services in Shropshire (Future Fit) forms part of the system plan to find where £74 million could potentially be used differently and more effectively to improve services for the local population.

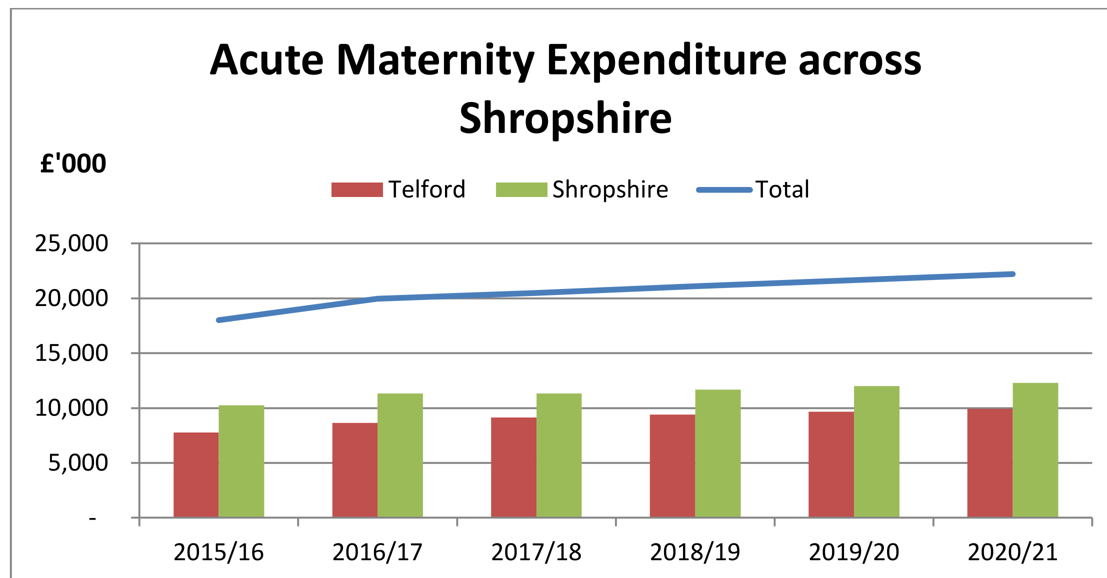
Added to the proposals NHS providers have a target of saving £62 million through efficiency improvements, successful implementation of the STP will put Shropshire and Telford & Wrekin in a good position at the end of the next five years to have services which are sustainable in the long term as well as meeting the public's healthcare needs more effectively.



The LMS sits within the STP and will need to deliver maternity transformation within this context. The current main provider of maternity services, Shrewsbury and Telford Hospitals NHS Trust, is currently running the service at a loss of £7m per year. This will need to be addressed as part of this plan.

Cost pressures have been identified by our main provider in terms of additional midwives to meet Birthrate plus standards and additional sonographers for extra scans. The outcome of the Midwife Led Unit (MLU) review may also have an impact on the financial sustainability of community MLUs. Savings opportunities should materialise due to a reduction in incidences of harm, time savings due to the development and rollout of an electronic care record, increasing home births and reductions in use of agency staff. As the plan progresses a full activity and finance model will be worked up in line with the current STP and Future Fit assumptions.[17]

[16] For further information please refer to Appendix 1
[17] For further information please refer to Appendix 2.3




This graph shows how much is currently spent on maternity services across the local health economy. The spend has been split between the two clinical commissioning groups and shows how spend has increased over the last 3 years. The graph then goes on to show projected spend up to 2020/21 based on the current growth assumptions within the STP.

- **Note that 2017/18 figures are the forecast position for the year**
- **Note that 2018/19 projected figures are based on growth assumptions within the Shropshire STP (3.0% 2018/19, 2.7% 2019/20 and 2.6% 2020/21)**

On average 94% of the spend represented above is spent at Shrewsbury and Telford Hospitals NHS Trust.

The needs of women accessing maternity services are assessed and classified against three different pathways, which are defined at a national level (standard, intermediate and intense). The proportion of women within each of the different pathways in 2016/17 in Shropshire, Telford and Wrekin is provided in the table below and includes a comparison to other areas. The plan aims to reduce the number of women with high risk pregnancies and also therefore reduce the associated costs.

| | | Number (%) Women | | |
|---|---|---|---|---|
| Stage of Pregnancy | Level of Need | Shropshire | Telford & Wrekin | West Midlands CCGs 2015/16 |
| Antenatal | Standard | 1450<br>-51% | 892<br>-39% | 49.20% |
| | Intermediate | 1134<br>-40% | 1147<br>-51% | 41.80% |
| | Intense | 264<br>-9% | 220<br>-10% | 9% |
| Delivery | Without complications/co-morbidities | 2133<br>-80% | 1720<br>-78% | - |
| | With complications/co-morbidities | 528<br>-20% | 473<br>-22% | - |
| Postnatal | Standard | 1643<br>(63.4%) | 1097<br>-55.80% | 70.60% |
| | Intermediate | 940<br>-36.30% | 860<br>-43.70% | 28% |
| | Intense | 7<br>-0.30% | 9<br>-0.50% | 1.40% |

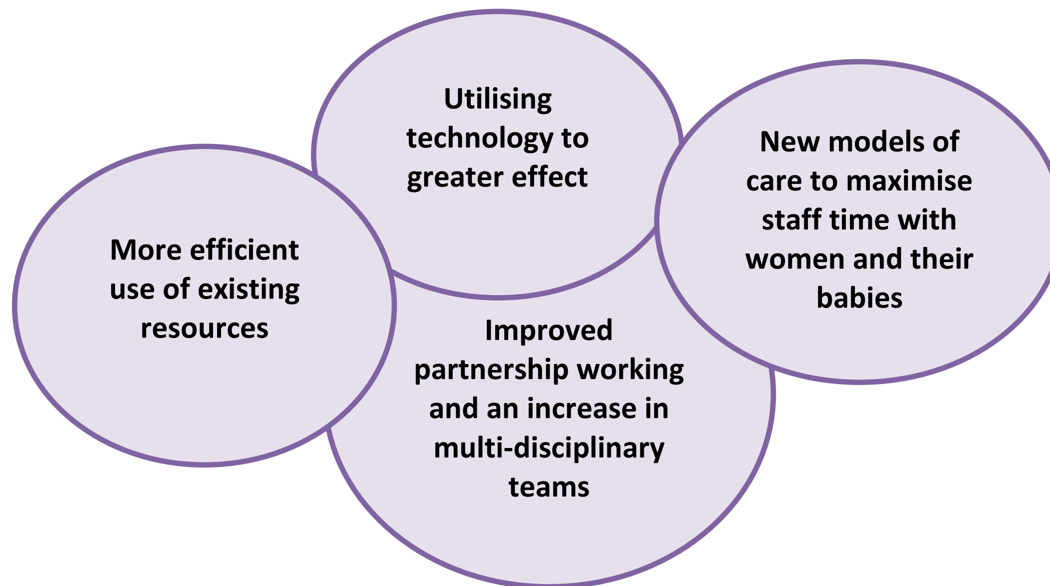
The maternity pathway payment system was introduced in April 2013 to:

- reduce variance in the way organisations describe and record antenatal and postnatal care
- encourage more proactive care, delivered closer to home
- encourage a more woman-focused approach to maternity care

For each of the stages shown above, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care, the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need.

Women may still receive some of their care from a different provider for clinical reasons or to support their choice. This care is paid for by the lead provider that will have received the entire pathway payment from the commissioner.

The majority of the maternity transformation will need to be delivered by the Local Maternity System within existing resources. This will be achieved and sustained through:






The Local Maternity System has received funding from NHS England to support transformation activities. This funding (£77k 2017/18, £150k 2018/19) has been allocated to secure a Programme Manager, Project Support Officer and Clinical Backfill as well as co-production and engagement activity.

To support the pace and scale of transformation required, the Local Maternity System will seek to secure additional funding/reduce existing spend, where available. This will include the following:

- NHS England Transformation Funding
- West Midlands Perinatal Mental Health Service User Forum Development Funds 17/18
- Perinatal mental health community services development fund wave 2
- CNST Incentive Scheme

Further detail on funding the transformation is provided in Appendix 11.

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## 10 Delivering the vision – the Programme of transformation

***The programme of transformation is still in the early stages. Some of the detail in relation to specifically what will be delivered is not yet known. The details will be confirmed once the reviews set out in workstream plans are complete. Once all the reviews are complete the future maternity offer can be confirmed.***

***The proposals from each of the reviews will set out in detail how service, pathway and process improvements will be made to ensure the requirements of Better Births are delivered, including in relation to:***

- ***Improving safety of maternity care***
- ***Personalised care planning***
- ***Choice of services***
- ***Continuity of carer***
- ***Increasing the number of women giving birth in midwifery led settings***
- ***Perinatal mental health***

| Shropshire, Telford and Wrekin Maternity Offer | | |
|---|---|---|
| | **Current Offer** | **Offer 31.03.2021** |
| **Before Pregnancy** | - All women have access to universal public health services relating to healthy lifestyles<br>- Women with a specialist need have access to mental health services | - Women will receive targeted support to help them lead a healthy lifestyle before, during and after pregnancy<br>- Staff receive regular training and up to date information about mental health and healthy lifestyles for those planning a family<br>- All women have access to a pre-conception health check<br>- All women have access to advice and support in relation to their emotional health and wellbeing |
| **Antenatal** | - Access to services is unclear and disjointed<br>- All women have the same team of 4-6 midwives caring for them throughout their pregnancy<br>- Women arrange their own appointments throughout pregnancy<br>- Ultrasound scanning is available in most parts of the county<br>- Day Assessment is available in some parts of the county<br>- Obstetric clinics are available in some parts of the county<br>- All women have hand held notes | - Access to services is through a single route, which is clear and well publicised<br>- All women have the same team of up to 4 midwives caring for them throughout their pregnancy<br>- Women are provided with a plan of all appointments at the start of pregnancy, which fit around their work and personal commitments<br>- Ultrasound scanning is available in all parts of the county<br>- Day assessment is available in all parts of the county |

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| | - All women have access to general information within the handheld notes and online, including in relation to mental health<br>- Women with an identified mental health need receive support through a specialist service | - Obstetric clinics are available in all parts of the county<br>- All women have access to electronic, personalised care plans<br>- All women have access to electronic personalised information and advice<br>- All women have access to peer support<br>- All women have access to support with their emotional health and wellbeing |
| **Birth** | - There is a full choice of birth settings available (Consultant Led Unit, Alongside Midwifery Unit, Standalone Midwifery Unit and Home Birth)<br>- Some women know the midwife delivering their baby/ies | - There is a full choice of birth settings available (Consultant Led Unit, Alongside Midwifery Led Unit, Standalone Midwifery Led Unit and Home Birth)<br>- Most women know the midwife delivering their baby/ies<br>- More women have a midwifery-led birth |
| **Neonatal** | - Babies can access a Neonatal Unit offering Intensive Care, High Dependency and Special Care cots within the county<br>- The reason for babies needing to access the neonatal unit are examined by a multi-disciplinary group using the ATAIN programme template and identify and implement service improvements.<br>- Newborn Infant Physical Examination (NIPE) takes place within 72 hours at a time and place convenient for the mother.<br>- Transitional Care: Babies that are small, early or those born to mothers with diabetes, but do not need specialist neonatal care, may require transitional care. Such care aims to keep mother and baby together. Currently in SaTH this is offered on the postnatal ward. There is no specific area on the ward. Babies and mothers are kept together and cared for by midwives. Some babies (up to 4) are kept in incubators. | - Babies can access a Neonatal Unit offering Intensive Care, High Dependency and Special Care cots within the county<br>- The reason for babies needing to access the neonatal unit are examined by a multi-disciplinary group using the ATAIN programme template and identify and implement service improvements.<br>- Newborn Infant Physical Examination (NIPE) takes place within 72 hours at a time and place convenient for the mother.<br>- New transitional care models are in place to reduce unnecessary admissions to neonatal units, keep mother, and baby together.<br>- Regular, multidisciplinary local reviews identify why a term baby has been admitted to the neonatal unit and implement service improvements. |
| **Postnatal** | - All women have the same team of 4-6 midwives caring for them in the community after they've had their baby/ies<br>- Health Visitors trained in cognitive behavioural therapy support women with their emotional wellbeing<br>- Women with an identified mental health need receive support through a specialist service | - All women have the same team of up to 4 midwives caring for them in the community after they've had their baby/ies. This is the same team of midwives who cared for them during pregnancy.<br>- All women have access to support with their emotional health and wellbeing |

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|---|---|---|
| | | - All women have access to peer support<br>- All women have access to electronic, personalised advice and information |
| **Quality and Safety** | - All women are asked about smoking status at booking. Women who are smoking at time of booking are referred to smoking cessation services<br>- All women are offered a CO test at booking<br>- Women at highest risk of fetal growth restriction are offered additional scans. Service standards are not currently in line with RCOG guidance.<br>- Women receive information and guidance about reduced fetal movements throughout pregnancy.<br>- CTG monitors, with on-board electronic analysis, are located in all of the MLUs and the CU.<br>- The CCGs monitor the quality of services using a quality dashboard<br>- The Patient Experience Team conduct investigations into patient safety incidents and ensure improvements are made.<br>- Lead Midwife and Lead Consultant for risk add additional expertise to identifying and implementing improvements. | - All women are asked about smoking status at booking. Women who are smoking at time of booking are referred to smoking cessation services.<br>- Smoking cessation services run alongside local antenatal services allowing women to attend both appointments on the same day in the same location<br>- All women are offered a CO test at booking<br>- Women at highest risk of fetal growth restriction are offered additional scans. Services offered are in line with RCOG guidance.<br>- Ultrasound scan locations are targeted to areas of high need to improve uptake.<br>- Women receive information and guidance about reduced fetal movements throughout pregnancy.<br>- CTG monitors, with on-board electronic analysis, are located in all of the MLUs and the CU.<br>- Intrapartum CTGs are archived electronically for review and teaching.<br>- Intrapartum CTGs are displayed live outside the labour room in order for staff to assess using fresh eyes on a regular basis throughout labour.<br>- The LMS partners monitor the quality of services across the pathway using a LMS joint quality dashboard.<br>- The Patient Experience Team conduct investigations into patient safety incidents and ensure improvements are made.<br>- Lead Midwife and Lead Consultant for risk add additional expertise to identifying and implementing improvements.<br>- Detection rates using the GAP software assess the effectiveness of the service in the detection of FGR.<br>- Enhanced training programme is in place to ensure high quality investigations are undertaken. |

## Workstream one: Maternity and newborn service configuration

**This workstream includes:**

- Review of the current service configuration for maternity and new-born services
- Implementation of the recommendations from the 'Action on Neonatal Mortality' programme
- Development and implementation of recommendations for service improvements in line with *Better Births* for midwifery led services, consultant led services and neonatal pathways
- Development and implementation of personalised care plans
- Development and implementation of outcomes and performance monitoring framework
- Development and implementation of improved quality and safety improvement system

**Outcomes:**

- Services are safer
- Women have a choice in the services they receive throughout pregnancy, during birth and after the baby is born
- Women understand the care they are receiving and feel involved in decisions about their care
- Women and their families find it easy to access a range of services related to pregnancy, birth and early parenthood
- Women receive care that is personal to their needs and circumstances



**Key activities**

| Activities | Timeframe |
|---|---|
| Midwifery led services review | Q4 2017/18 |
| Consultant unit review | Q1 2018/19 |
| Neonatal pathways review | Q1 2018/19 |
| Development of maternity offer | Q2 2018/19 |
| Development and implementation of Personalised Care Plan Framework | Q1 2018/19 |
| Development and implementation of new service pathways to improve transition | Q1 2018/19 |
| Development and implementation of outcomes and performance monitoring framework | Q2 2018/19 |
| Implementation of quality and safety improvement system | To be confirmed |

**Success will be measured by:**

- A reduction in the rates of stillbirth and neonatal death, maternal death and brain injuries
- An increase in the number of women giving birth in community settings
- An increase in the number of women who have continuity of carer throughout pregnancy, birth and after their baby is born
- An increase in the proportion of women reporting they felt they had a choice about their care during pregnancy, birth and after their baby is born
- An increase in the proportion of women reporting that they understood about the care they received and felt involved in decisions about their care
- An increase in the number of women who have personalised care plans
- An increase in the number of women with access to electronic records and information
- Evidencing improvements in investigating and learning from incidents and sharing learning with others
- Evidencing full engagement in the development and implementation of the national maternity and neonatal quality improvement programme
- The proportion of women accessing maternity services before 10 weeks of pregnancy
- Earlier provision of appropriate information at the onset of pregnancy
- Fewer days spent accessing maternity care although receiving more care episodes for all women
- A reduction in the number of days in which women and their babies are separated whilst their baby receives care

**Related recommendations in *Better Births***

1.1 : Every woman has a personalised care plan
1.3 : Women can choose the provider of their care through a NHS Personal Maternity Care Budget
1.4 : Women can make decisions about the support they need during birth and where they would prefer to give birth
2.1 : Every woman has a midwife who is part of a team of 4-6 midwives
2.2 : Each team of midwives has an identified obstetrician
2.3 : Community hubs should enable them to access care in the community from their midwife and from a range of others
services, particularly for antenatal and postnatal care.
2.4 : Midwives liaise closely with obstetric, neonatal and other services to ensure women get what they need
3.1 : Providers have a board level lead for maternity services, routinely monitor quality and safety and take necessary action to improve
3.3 : Rapid referral protocols are in place to ensure that the woman and her baby can access more specialist care when they need it
3.4 : Teams collect data on quality and outcomes in order to improve services
3.5 : There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.
3.6: There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly
4.2: Women have access to their midwife as they require after having their baby
4.3 : There is smooth transition between midwife, obstetric and neonatal care and to ongoing care in the community
4.4 : A review of neonatal services has taken place
5.1 : Those who work together, train together
5.2 : Multi-professional training

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| 5.4 : A nationally agreed set of indicators is in place to track, benchmark and improve the quality of maternity services<br>5.5 : Multi-professional peer review is available and used locally<br>6.1: Local Maternity System is in place<br>6.2 : Maternity Clinical Networks are in place and Shropshire, Telford and Wrekin are active members<br>6.3 : Commissioners are commissioning against clear outcome measures. Providers are empowered to make service improvements<br>6.4 : Early adopter sites are up and running |

| Workstream two: health and wellbeing | |
|---|---|
| **This workstream includes:**<br><br>– Implementing the offer of preconception health checks<br>– Enhancing existing initiatives and introducing new initiatives to improve the health and wellbeing of parents/carers and future parents/carers, including in relation to smoking, obesity, diabetes, hypertension, screening, immunisations and vaccines.<br>– Enhance existing initiatives and introducing new initiatives to ensure every child gets the best start in life<br>– Working across the health economy to ensure advice, support and services are in place for women before, during and after pregnancy in relation to health and wellbeing<br>– Ensure services are in place to promote pregnancy planning and the promotion of contraceptive choices (including in the post partum period)<br>– To ensure the workforce is well equipped to offer advice support and signposting to improve their health<br>– Ensuring preventative services and advice during pregnancy are offered across the county within community hubs<br>– Delivering a programme of Making Every Contact Count (MECC) training to a range of professionals<br>– Strengthening links and pathways between maternity, health visiting and other professionals to offer early support with health and wellbeing | **Outcomes:**<br>– Women have a healthy lifestyle before getting pregnant<br>– Women are healthy during pregnancy<br>– Women understand how to keep themselves and their baby healthy in the longer term<br>– Professionals work within a culture where improving health and wellbeing and reducing health inequalities is understood and acted upon<br>– Babies and infants are healthier and grow to be healthy children and adults |

**Key activities**

| Activities | Timeframe |
|---|---|
| Improve uptake and impact of making every contact count (MECC) | Q1 2018/19 |
| Develop and implement new information and pathways in relation to contraception and sexual health. | Q1 2018/19 |
| Improve training for professionals and access for women in relation to healthy lifestyle services | Q1 2018/19 |
| Stop smoking services review | Q4 2018/19 |
| Obesity services review. | Q1 2018/19 |
| Diabetes services review. | Q3 2018/19 |
| Hypertension services review. | Q3 2018/19 |
| Breastfeeding services review. | Q2 2018/19 |
| Screening Programmes review. | Q3 2018/19 |
| Immunisation Programmes review. | Q3 2018/19 |

**Success will be measured by:**

- An increase in the uptake of screening and immunisations for pregnant women
- An increase in the update of screening and immunisations for babies and infants
- An increase in the number of professionals trained in MECC
- An increase in the range of professionals trained in MECC
- A reduction in the prevalence of obesity, smoking, diabetes and hypertension during pregnancy
- An increase in breastfeeding rates

**Related recommendations in *Better Births***

2.3 Community Hubs should enable women to access care in the community from a range of services
2.4 Midwives liaise closely with obstetric, neonatal and other services to ensure women get what they need
4.2 Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby
4.3 There is smooth transition between midwife, obstetric and neonatal care and to ongoing care in the community
5.1 Those who work together, train together
5.2 Multi-professional training

## Workstream three: Perinatal Mental Health

**This workstream includes:**

- Developing and publishing new information for women from pre-conception to 12 months post-delivery with advice on how to improve their emotional mental health and wellbeing
- Developing and implementing improved perinatal mental health services
- Improving partnership working
- Upskilling the workforce
- Promoting holistic care that supports parent-infant interaction and family relationships

**Outcomes:**

- Women understand how to improve their emotional mental health and wellbeing
- Women feel confident in managing their emotional health and wellbeing
- Women feel well supported in relation to their emotional health and wellbeing
- Professionals feel confident in their knowledge of perinatal mental health and the local services available

**Key activities**

| Activities | Timeframe |
|---|---|
| Improved skills and pathways within primary care | Q4 2017/18 |
| Improved skills and pathways within maternity services | Q4 2017/18 |
| Improved information on and access to mental health advice and support in the community for women of childbearing age | Q1 2018/19 |
| Increased availability of specialist perinatal mental health services | Q1 2018/19* |

*If successful with a bid for early funding, the new service will commence during 2018/19. Otherwise, the transformation will occur in 2019/20 when the additional funds will be received.

**Success will be measured by:**

- An increase in the proportion of women reporting they are confident in managing their emotional mental health and wellbeing
- An increase in the proportion of women reporting that they receive regular information and advice in relation to managing their emotional mental health and wellbeing
- An increase in investment in Perinatal Mental Health Services
- An increase in the proportion of professionals who report they are confident in giving advice and support to pregnant women and new mothers in relation to their emotional mental health and wellbeing
- An increase in the range of services available for women in Shropshire, Telford and Wrekin in relation to perinatal mental health

**Related recommendations in *Better Births***
2.3: Community Hubs should enable women to access care in the community from a range of services
2.4: Midwives liaise closely with obstetric, neonatal and other services to ensure women get what they need
3.3: Rapid referral protocols are in place to ensure that the woman and her baby can access more specialist care when they need it
4.1: There is significant investment in perinatal mental health services
4.2: Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby.
4.3: There is smooth transition between midwife, obstetric and neonatal care and to ongoing care in the community
5.1: Those who work together, train together
5.2: Multi-professional training

| Cross Cutting theme one: workforce | |
|---|---|
| **This workstream includes:**<br><br>- Establishing the current workforce baseline for the LMS.<br>- Identifying future workforce configuration based on the transformed service model.<br>- Implementation of role transformation.<br>- Implementation of community hub teams.<br>- Workforce planning to meet demand and manage turnover and retention; ensuring sufficient flexibility, capacity and capability in the service<br>- Ensuring sufficient flexibility, capacity and workforce planning to meet demand.<br>- Ensuring organisational Boards routinely monitor information about quality, including safety and take necessary action to improve quality.<br>- Implementation of professional midwifery advocate roles (underpinning feedback/learning cycle).<br>- Developing and implementing a robust workforce development plan across the local health economy to embed a culture of training together as well as ensuring the local health economy has the right numbers and skills of people with continuous development and multi-disciplinary team working.<br>- Influencing cultural change to enhance flexibility and reach of the workforce in relation to health economy approach to care in ensuring a women focused ethos and culture of co-production.<br>- Supporting learning and development systems.<br>- Identifying and supporting Maternity Services Champions. | **Outcomes:**<br>- Every woman knows the midwife who delivers her care throughout pregnancy, during birth and after the baby is born.<br>- Every woman receives care that is joined up, as professionals involved in her care work closely together.<br>- Women and their families receive a good quality service that is constantly improving.<br>- People working in and with maternity services feel well supported and valued.<br>- People working in and with maternity services feel proud of the services available.<br>- People working in and with maternity services routinely work together and train together. |

**Key Activities**

| Activities | Timeframe |
|---|---|
| Establish the current workforce baseline for the LMS | Q4 2017/18 |
| Identify future workforce configuration | Q4 2017/18 |
| Develop and implement a workforce development plan across the local health economy | Q2 2018/19 |
| Influence cultural change to ensure a women focused ethos and culture of co- production | Q4 2018/19 |

**Success will be measured by:**

- Appropriate skill mix within teams across the health economy taking into account role redesign and transformation
- An increase in the number of women who know the midwives caring for them during pregnancy, birth and after the baby is born
- An increase in the number of multi-professional training opportunities available
- An increase in the number of professionals accessing multi-professional training
- An improvement in satisfaction and advocacy rates reported through staff surveys

**Related recommendations in *Better Births***

2.1 Every woman has a midwife who is part of a team of 4-6 midwives.
2.2 Each team of midwives has an identified obstetrician.
3.2 Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi professional training. CQC should consider these issues during inspections.
3.6 There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly.
4.1 There is significant investment in perinatal mental health services.
4.2 Women have access to their midwife, as they require after having their baby.
5.1 Those who work together, train together.
5.2 Multi-professional training.

| Cross Cutting theme two: Digital Roadmap | |
|---|---|
| **This workstream includes:**<br><br>- Improving connectivity across the area to improve record keeping and information sharing.<br>- Development and implementation of an electronic patient record.<br>- Identification/development and implementation of Digital information/ apps for women and their families in relation to becoming pregnant, pregnancy and having a baby.<br>- Identification of potential investment required in relation to software, infrastructure and equipment.<br>- Identifying women's preferences in relation to format of an electronic personalised care plan.<br>- Work with professional stakeholders to identify how systems can better link together/organisations can work from the same system to share information.<br>- Work with information system providers to develop a system that meets the needs of women and the professionals working with them.<br>- Work with women to develop an interactive digital maternity tool that is kept up to date. | **Outcomes:**<br>- Women and their families only need to tell their story once.<br>- Health professionals have up to date information at all times.<br>- Every woman has easy access to a personalised care plan.<br>- Every woman and their family has access to unbiased information through an interactive digital maternity tool. |

**Key Activities**

| Activities | Timeframe |
|---|---|
| Identify baseline and develop integrated improvement plan across LMS | Q1 2018/19 |
| Develop and Implement Electronic Patient Record | Q4 2018/19 |
| Develop systems around Web-based Patient Information | Q4 2017/18 |
| Develop systems to enable effective Information Sharing | Q1 2018/19 |
| Identify and implement solutions to improve connectivity and remote access | Q4 2018/19 |

| **Success will be measured by:**<br><br>- An increase in the number of professionals with access to electronic patient records<br>- An increase in the number of women with access to electronic patient records<br>- An increase in the number of midwives with remote access to up to date electronic patient information<br>- A reduction in the number of professionals reporting issues with information sharing<br>- An increase in the number of women reporting that they only needed to tell their story once |
|---|
| **Related recommendations in *Better Births***<br>1.1 Every woman should develop a personalised care plan, with their midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses and after the birth.<br>1.2 Unbiased information should be made available to all women to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what services are available locally. This should be through their digital maternity tool.<br>5.3 Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information. |

## Cross Cutting Theme Three: Maternity Voices

**This workstream includes:**

- Ensuring that the LMS Plan is fully co-produced by the establishment of the Maternity Voices Partnership and that the Maternity Voices Partnership is self-sustaining
- Developing and implementing a co-production approach that all partners will use in designing, delivering and improving maternity services
- Develop and implement a communication and engagement plan
- Upskilling the workforce in the 'Experience Led Commissioning' approach to service re-design

**Outcomes:**

- Women and their families feel that they have a say in how services are designed and delivered
- Professionals from a range of agencies feel that they have a say in how services are designed and delivered
- Women and their families feel well informed about maternity services
- People who are or have used the services are fully engaged in the Maternity Voices Partnership Co-ordinating Group, if they wish to be
- People who use or have used the services, who wish to be, are part of the wider Maternity Voices Partnership and know how to participate
- The other workstreams are able to engage / know how to engage with people who are or have used maternity services.

**Key Activities**

| Activities | Timeframe |
|---|---|
| Understand issues and ideas regarding information sharing and identify potential solutions | From Q3 2017/18 |
| Design and implement co-production approach | From Q4 2017/18 |
| Develop and implement a communication and engagement plan | From Q3 2017/18 |

**Success will be measured by:**

- A reduction in the number of professionals reporting issues with information sharing
- An increase in the number of women reporting that they only needed to tell their story once
- An increase in the number of women who feel involved in decisions about the care they receive
- An increase in the number of women and their families who feel they can influence improvements to services
- An increase in the number of women and their families who feel they can influence system change
- An increase in the number of women and their families who feel well informed about maternity services
- An increase in the number of women and their families who know where to go to get information about maternity services

**Related recommendations in *Better Births***
1.2: Unbiased information should be made available to all women to help them make their decisions and develop their care plan
3.2: Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training. CQC should consider these issues during inspections
5.1: Those who work together should train together. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible
5.3: Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information.
RP16: Local maternity systems should be responsible for ensuring that they co-design services with service users and local communities
RP17: Maternity Voices Partnership will need to establish a committee structure
RP18: A Maternity voices partnership should have a defined programme of work and be adequately resourced

## Appendices:

Appendix 1 Shropshire and Telford STP
Appendix 2 Maternity
Appendix 3 Health and Wellbeing
Appendix 4 Perinatal Mental Health
Appendix 5 Neonatal
Appendix 6 Safety and Quality
Appendix 7 Workforce
Appendix 8 Engagement and Co production
Appendix 9 Workstream Project Plans
Appendix 10 Self Assessment against Better Births and Performance Monitoring Framework
Appendix 11 Funding the Transformation



**References: (End Notes)**


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